

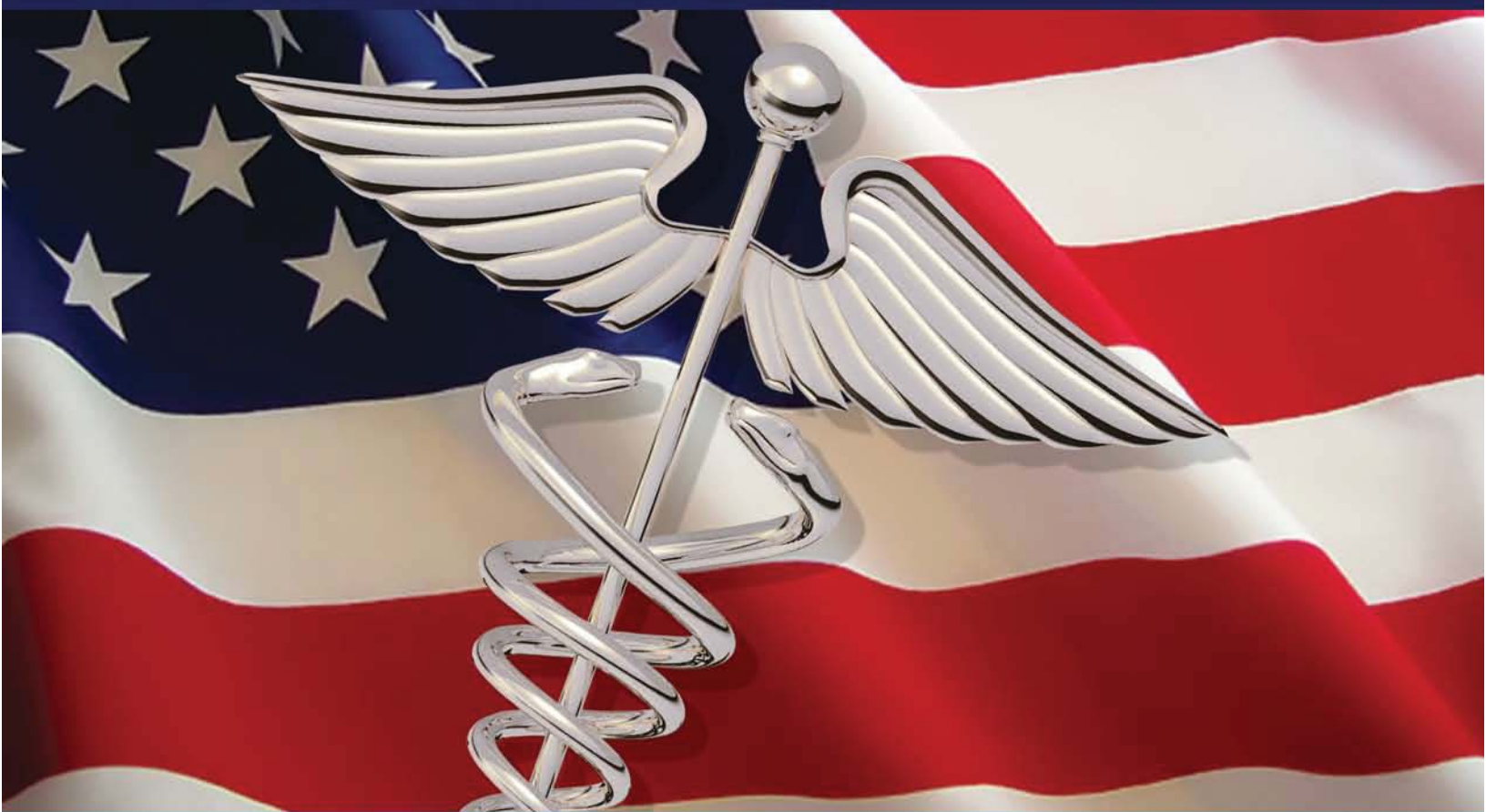
# VA/DoD Clinical Practice Guideline

## Management of Post-Traumatic Stress

Version 2.0

**GUIDELINE SUMMARY**

**2010**



**VA/DoD Evidence Based Practice**





**DEPARTMENT OF VETERANS AFFAIRS  
DEPARTMENT OF DEFENSE**



**VA/DoD CLINICAL PRACTICE GUIDELINE  
FOR  
THE MANAGEMENT OF  
POST-TRAUMATIC STRESS  
GUIDELINE SUMMARY**

*Prepared by:*

**The Management of Post-Traumatic Stress  
Working Group**

*With support from:*

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and  
Quality Management Directorate, United States Army MEDCOM**

*Full guideline available at:*

*<http://www.healthquality.va.gov> or <https://www.qmo.amedd.army.mil>*

**QUALIFYING STATEMENTS**

The Department of Veterans Affairs (VA) and The Department of Defense (DoD) guidelines are based on the best information available at the time of publication. They are designed to provide information and assist decision-making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

Variations in practice will inevitably and appropriately occur when providers take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

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## INTRODUCTION

This 2010 VA/DoD Post-Traumatic Stress Guideline Update builds on the *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress* published in 2004. The goal of this update is to integrate the results of recent research and update the recommendations of the original guideline to reflect the current knowledge of effective treatment interventions.

### Target Population:

This guideline applies to adult patients with traumatic stress reaction treated in any VA or DoD clinical setting.

### Audiences:

The guideline is relevant to all health care professionals providing or directing treatment services to patients with post-traumatic stress at any VA/DoD health care setting.

The Working Group developed a list of questions that focused on the main issues of the guideline. An extensive literature search of relevant studies has been conducted and selected studies that met inclusion criteria have been reviewed. The group had three face-to-face meetings and a series of conference calls in which the evidence was reviewed and specific recommendations were discussed.

### Review of Literature and Evidence:

Recommendations for the performance or inclusion of specific procedures or services in this guideline were derived through a rigorous methodological approach that included the following:

- ★ Determining appropriate criteria, such as effectiveness, efficacy, population benefit, and patient satisfaction
- ★ Performing a comprehensive literature search and selection of relevant studies from January 2002 to August 2009 to identify the best available evidence and ensure maximum coverage of studies at the top of the hierarchy of study types
- ★ Reviewing the selected studies to determine the strength of the evidence in relation to these criteria
- ★ Formulating the recommendations and grading the level of evidence supporting each recommendation

This 2010 update builds on the 2004 version of the guideline and incorporates information from the following existing evidence-based guidelines/reports identified by the Working Group as appropriate seed documents:

- ★ International Society for Traumatic Stress Studies. (2009). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. Foa, E.B., Keane, T.M., Friedman, M.J., & Cohen, J. (Eds). New York: Guilford Press.
- ★ Institute of Medicine. (2007). *Treatment of post-traumatic stress disorder: An assessment of the evidence*. Washington, DC: The National Academies Press.
- ★ American Psychological Association. (2009). Guideline watch (March 2009): Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Washington, DC: American Psychological Association.

Literature searches were conducted, covering the period from January 2002 through August 2009, that combined terms for post-traumatic stress, acute stress reaction (ASR), acute stress disorder (ASD), acute post-traumatic stress disorder, and chronic post-traumatic stress disorder. Electronic searches were supplemented by reference lists, and additional citations were suggested by experts. The identified and selected studies on those issues were critically analyzed, and the evidence was graded using a standardized format, based on the system used by the U.S. Preventive Services Task Force (USPSTF, 2007).

If evidence exists, the discussion following the recommendations for each annotation includes an evidence table identifying the studies that have been considered, the quality of the evidence, and the rating of the strength of the recommendation [SR]. The Strength of Recommendation, based on the level of the evidence and graded using the USPSTF rating system (see Table: Evidence Rating System), is presented in brackets following each guideline recommendation.

### Evidence Rating System

Strength of Recommendation (SR)	
A	A strong recommendation that clinicians provide the intervention to eligible patients. <i>Good evidence was found that the intervention improves important health outcomes and concludes that benefits substantially outweigh harm.</i>
B	A recommendation that clinicians provide (the service) to eligible patients. <i>At least fair evidence was found that the intervention improves health outcomes and concludes that benefits outweigh harm.</i>
C	No recommendation for or against the routine provision of the intervention is made. <i>At least fair evidence was found that the intervention can improve health outcomes, but concludes that the balance of benefits and harms is too close to justify a general recommendation.</i>
D	A recommendation is made against routinely providing the intervention to asymptomatic patients. <i>At least fair evidence was found that the intervention is ineffective or that harms outweigh benefits.</i>
I	The conclusion is that the evidence is insufficient to recommend for or against routinely providing the intervention. <i>Evidence that the intervention is effective is lacking, or poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</i>

\*SR = Strength of Recommendation

Where existing literature was ambiguous or conflicting, or where scientific data were lacking on an issue, recommendations were based on the **clinical experience** of the members of the Working Group.

### Post-Traumatic Stress:

Post-traumatic stress consists of a spectrum of traumatic stress disorders—hence, this Clinical Practice Guideline for the Management of Post-Traumatic Stress. These disorders can be arranged along a temporal axis, from Acute Stress Reaction, to Acute Stress Disorder, Acute PTSD, and Chronic PTSD. Each of these may be associated with serious mental and physical co-morbidities. Some survivors will experience only a part of this spectrum, while others will progress through the entire range.

**Acute Stress Reaction (ASR)** is not a DSM IV diagnosis and is used in this guideline to refer to a range of transient conditions that develop in response to a traumatic event. Onset of at least some signs and symptoms may be simultaneous with the trauma itself or within minutes of the traumatic event and may follow the trauma after an interval of hours or days. In most cases symptoms will disappear within days (even hours).



**Combat and Operational Stress Reaction (COSR)** reflects acute reactions to a high-stress or combat-related event. ASR/COSR can present with a broad group of physical, mental, and emotional symptoms and signs (e.g., depression, fatigue, anxiety, decreased concentration/memory, hyperarousal, and others) that have not resolved within 4 days after the event, and after other disorders have been ruled out.

**Acute Stress Disorder (ASD)**, a diagnosis defined by DSM IV, occurs when the individual has experienced trauma(s) as described above, has symptoms lasting more than two days, but less than one month after exposure to the trauma (may progress to PTSD if symptoms last >one month), and exhibits re-experiencing, avoidance, increased arousal, and at least three out of five dissociative symptoms.

**Post-Traumatic Stress Disorder (PTSD)** is a clinically significant condition with symptoms continuing more than 1 month after exposure to a trauma that has caused significant distress or impairment in social, occupational, or other important areas of functioning. Patients with PTSD may exhibit persistent re-experiencing of the traumatic event(s), persistent avoidance of stimuli associated with the trauma, numbing of general responsiveness (not present before the trauma), and persistent symptoms of increased arousal (not present before the trauma). PTSD can also have a delayed onset, which is described as a clinically significant presentation of symptoms (causing significant distress or impairment in social, occupational, or other important areas of functioning) at least 6 months after exposure to trauma.

PTSD is further sub-divided into **Acute PTSD** (symptoms lasting more than one month, but less than three months after exposure to trauma) and **Chronic PTSD** (symptoms lasting more than three months after exposure to trauma). PTSD can appear alone (presenting with common symptoms of PTSD) or more commonly with other co-occurring conditions (persistent difficulties in interpersonal relations, mood, chronic pain, sleep disturbances, somatization, and profound identity problems) or psychiatric disorders (meeting DSM criteria for another disorder, such as substance abuse, depression, and anxiety disorder).

Recent research has shown that PTSD is highly prevalent among soldiers returning from combat duty. OEF/OIF/OND Veterans and Service Members who have sustained a concussion/mild traumatic brain injury (mTBI) in the combat environment are often at significantly greater risk of PTSD. Moreover, the diagnosis of either condition may be complicated by the fact that PTSD is associated with generalized health symptoms, including neurocognitive impairment and other symptoms in the persistent post-concussion syndrome definition.

Evidence-based practices to prevent and treat PTSD include screening, cognitive behavioral therapies, and medications. There are many new strategies involving enhancement of cognitive fitness and psychological resilience to reduce the detrimental impact of trauma. In terms of screening, evidence suggests that identifying PTSD early and quickly referring people to treatment can shorten their suffering and lessen the severity of their functional impairment. Several types of cognitive behavioral therapies, counseling, and medications have been shown to be effective in treating PTSD.

The VA and DoD health care systems have undergone significant changes in the past 10-15 years that are transforming the two into an integrated system that provides high-quality care. In response to the increased demands for services to treat OEF/OIF/OND Service Members and Veterans with PTSD, these systems have invested resources in expanding outreach activities, and enhancing the availability and timeliness of specialized PTSD services.

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## OVERVIEW OF GUIDELINE

This clinical practice guideline updates the 2004 version of the VA/DoD Guideline on Management of Post-Traumatic Stress.

The Working Group (WG) developed a revised, comprehensive clinical algorithm. The current revision incorporates the four Modules of the 2004 guideline into two Modules focusing on Acute Stress Reactions (ASR) and Post-Traumatic Stress Disorder (PTSD). Where evidence suggests differences in the management of Acute Stress Reactions (ASR), Acute Stress Disorder (ASD), and Post-Traumatic Stress Disorder (PTSD), specific treatment intervention recommendations are provided.

This effort drew heavily from the International Society for Traumatic Stress Studies clinical practice guideline (Foa et al., 2009). The VA/DoD Working Group reviewed this guideline and made the decision to adopt several of their evidence-based recommendations. Identified randomized controlled trials and systematic reviews published in the past 7 years have been carefully appraised and included in the analysis of the evidence for this update.

The Guideline includes a CORE Module that addresses primary and secondary prevention of PTSD and recommendations regarding screening and triage based on time passed since the traumatic event.

**Module A** incorporates the assessment, diagnosis, and management of symptoms of **Acute Stress Reaction (ASR)** in the immediate period after exposure to trauma, the management of **Acute Stress Disorder (ASD)**, and the effective early interventions to prevent progression of stress reactions to full PTSD. Additional recommendations were added for the assessment and management of **Combat and Operational Stress Reaction (COSR)**, addressing specific actions that the WG considered to be of importance for providers caring for Service Members with symptoms.

**Module B** addresses the diagnosis and management of patients with **Post-Traumatic Stress Disorder (PTSD)**. The WG revised the algorithm for this module into a patient-centered approach that emphasizes the decisions and interventions shown to be effective in treating PTSD, regardless of the treatment setting. This approach should allow for the use of the guideline as a starting point for innovative plans that improve collaborative efforts and focus on key aspects of care. The recommendations outlined in this guideline should serve as a framework for the care that is provided in specialty mental health care settings as well as in primary care. The optimal setting of care for the individual patient will depend on patient preferences, the level of expertise of the provider, and available resources.

**Module I** includes evidence-based recommendations regarding treatment interventions for prevention of PTSD (Section I-1); and for treatment of PTSD (Section I-2). Working Group consensus-based recommendations are added to this 2010 revision of the CPG (Section I-3) regarding specific adjunct treatment interventions that target specific symptoms frequently seen in patients with acute stress reactions (beyond the core symptoms of ASD/PTSD). These include sleep disturbance, pain, and anger. These consensus-based recommendations are aimed to help health care practitioners to provide brief symptom-focused treatment. The WG recognizes that PTSD is often accompanied by other psychiatric conditions. Such co-morbidities require clinical attention at the point of diagnosis and throughout the process of treatment. Disorders of particular concern are **substance use disorder, major depression**, and post-concussive symptoms attributed to **mild TBI**. The WG also recognizes the fact that few trials have been published that can provide guidance on how to manage PTSD that is complicated by co-morbid illness. The revised guideline includes recommendations based on the experience and opinion of the experts, providing suggestions for the approach to treatment of PTSD in the presence of co-morbid psychiatric conditions.

Finally, clinicians following these updated guidelines should not limit themselves only to the approaches and techniques addressed in the guideline. All current treatments have limitations—not all patients respond to them, patients drop out of treatment, or providers comfort or experience in using a particular intervention is limited. Creative integration of combined treatments that are driven by sound evidence-based principles is encouraged in the field.

#### **KEY POINTS ADDRESSED BY THIS GUIDELINE**

- ★ Triage and management of acute traumatic stress
- ★ Routine primary care screening for trauma and related symptoms
- ★ Diagnosis of trauma syndromes and co-morbidities
- ★ Evidence-based management of trauma-related symptoms and functioning
- ★ Collaborative patient/provider decision-making, education, and goal-setting
- ★ Coordinated and sustained follow-up
- ★ Identification of major gaps in current knowledge
- ★ Outline for psychological care in ongoing military operations
- ★ Proactive strategies to promote resilience and prevent trauma-related stress disorders
- ★ Standardized longitudinal care (DoD/VA, Primary Care/Mental Health)

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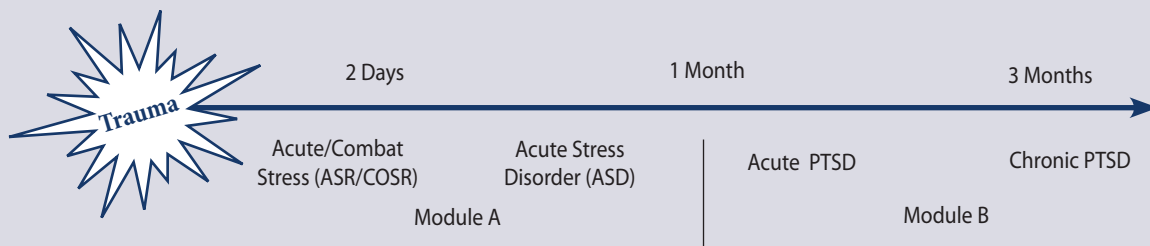
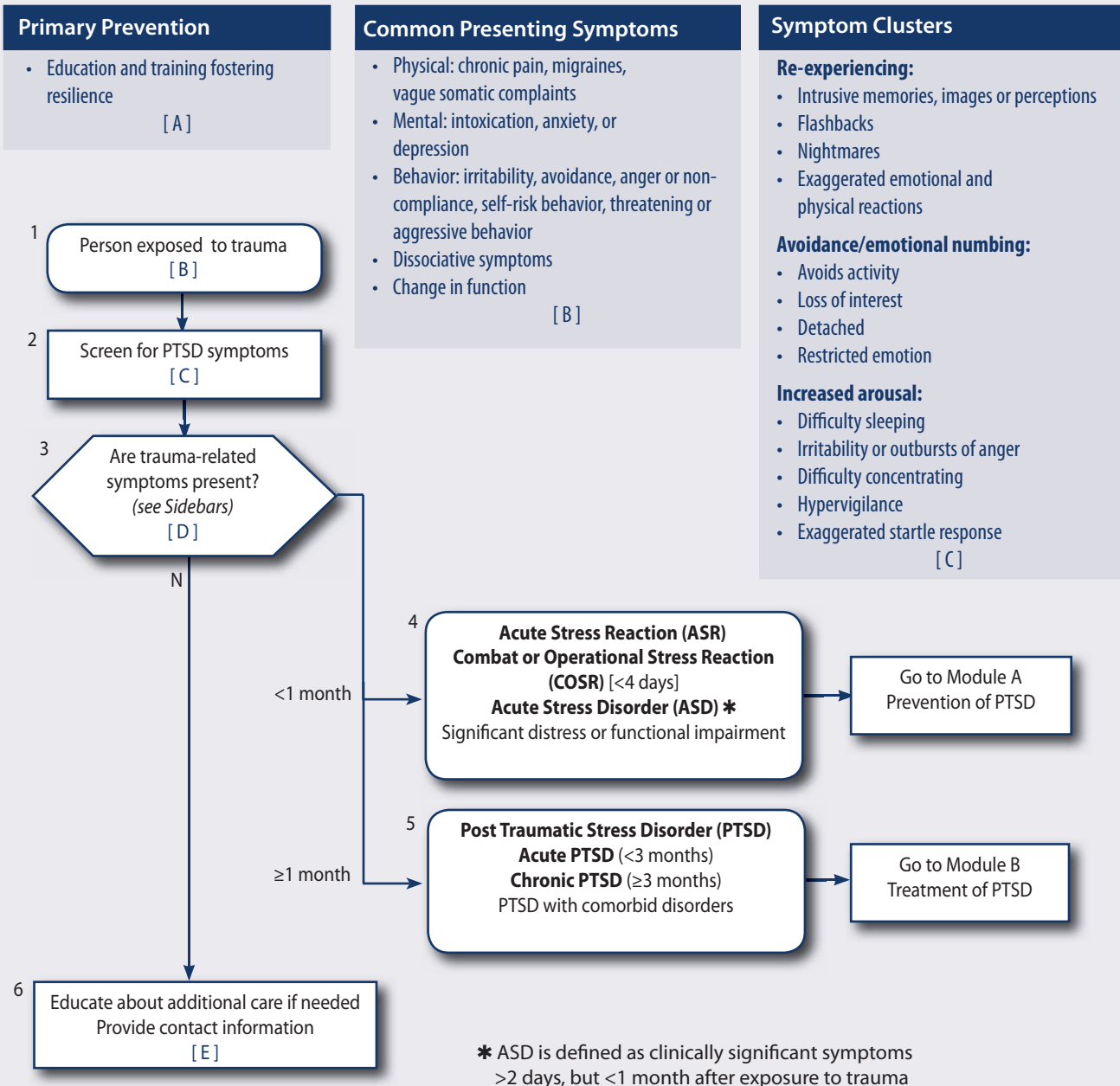
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## CORE MODULE: INITIAL EVALUATION AND TRIAGE

### ANNOTATIONS

#### *Annotation A. Education and Training to Foster Resilience*

1. In high-risk occupations, for which the probability of trauma exposure is moderate or high, efforts should be undertaken to increase the psychological resilience of workers to the negative effects of trauma exposure.

#### *Annotation B. Person Exposed to Trauma*

1. Persons exposed to trauma should be assessed for the type, frequency, nature, and severity of the trauma. [B]
2. Assessment should include a broad range of potential trauma exposures in addition to the index trauma.
3. Trauma exposure assessment instruments may assist in evaluating the nature and severity of the exposure.
4. Assessment of existing social supports and ongoing stressors is important.

#### *Annotation C. Screen for PTSD Symptoms*

1. All new patients should be screened for symptoms of PTSD initially and then on an annual basis, or more frequently, if clinically indicated due to clinical suspicion, recent trauma exposure (e.g., major disaster), or history of PTSD. [B]
2. Patients should be screened for symptoms of PTSD using paper-and-pencil or computer-based screening tools. [B]
3. There is insufficient evidence to recommend one PTSD screening tool versus another. However, the following screening tools have been validated and should be considered for use:
  - Primary Care PTSD Screen (PC-PTSD)
  - PTSD Brief Screen
  - Short Screening Scale for DSM IV PTSD
  - PTSD Checklist (PCL).
4. There is insufficient evidence to recommend special screening for members of any cultural or racial group or gender. [I]

#### *Annotation D. Are Trauma Related Symptoms Present?*

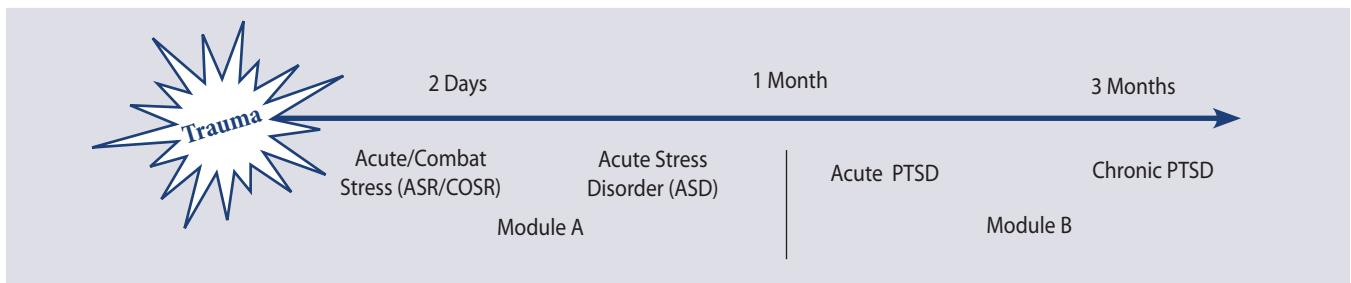
1. Individuals who are presumed to have symptoms of PTSD or who are positive for PTSD on the initial screening should receive a more detailed assessment of their symptoms.
2. Useful symptom-related information may include details such as time of onset, frequency, course, severity, level of distress, and degree of functional impairment.

3. The elapsed time since the exposure to trauma should be considered when assessing the risk of developing PTSD and determining the diagnosis and appropriate intervention (*see definitions of trauma exposure - Module A, Annotation A*).

**Annotation E. Educate About Additional Care If Needed, Provide Contact Information**

1. Pre- and post-trauma education should include helping the asymptomatic trauma survivor or responder understand that the acute stress reactions of other people are common and probably transient and do not indicate personal failure or weakness, mental illness, or health problems.
2. Education should include sufficient review of the many ways that post-traumatic problems can present, including symptoms in the ASD/PTSD spectrum, behavioral problems with family and friends, occupational problems, and the potential impact of alcohol or other substance misuse/abuse.
3. Education should also include positive messages by identifying and encouraging positive ways of coping, describing simple strategies to resolve or cope with developing symptoms and problems, and setting expectations for mastery and/or recovery.
4. Provide contact information, should post-traumatic symptoms emerge later.
5. Routine debriefing or formal psychotherapy is not beneficial for asymptomatic individuals and may be harmful. [D]

**Figure 1. Stress Reaction Timeline**



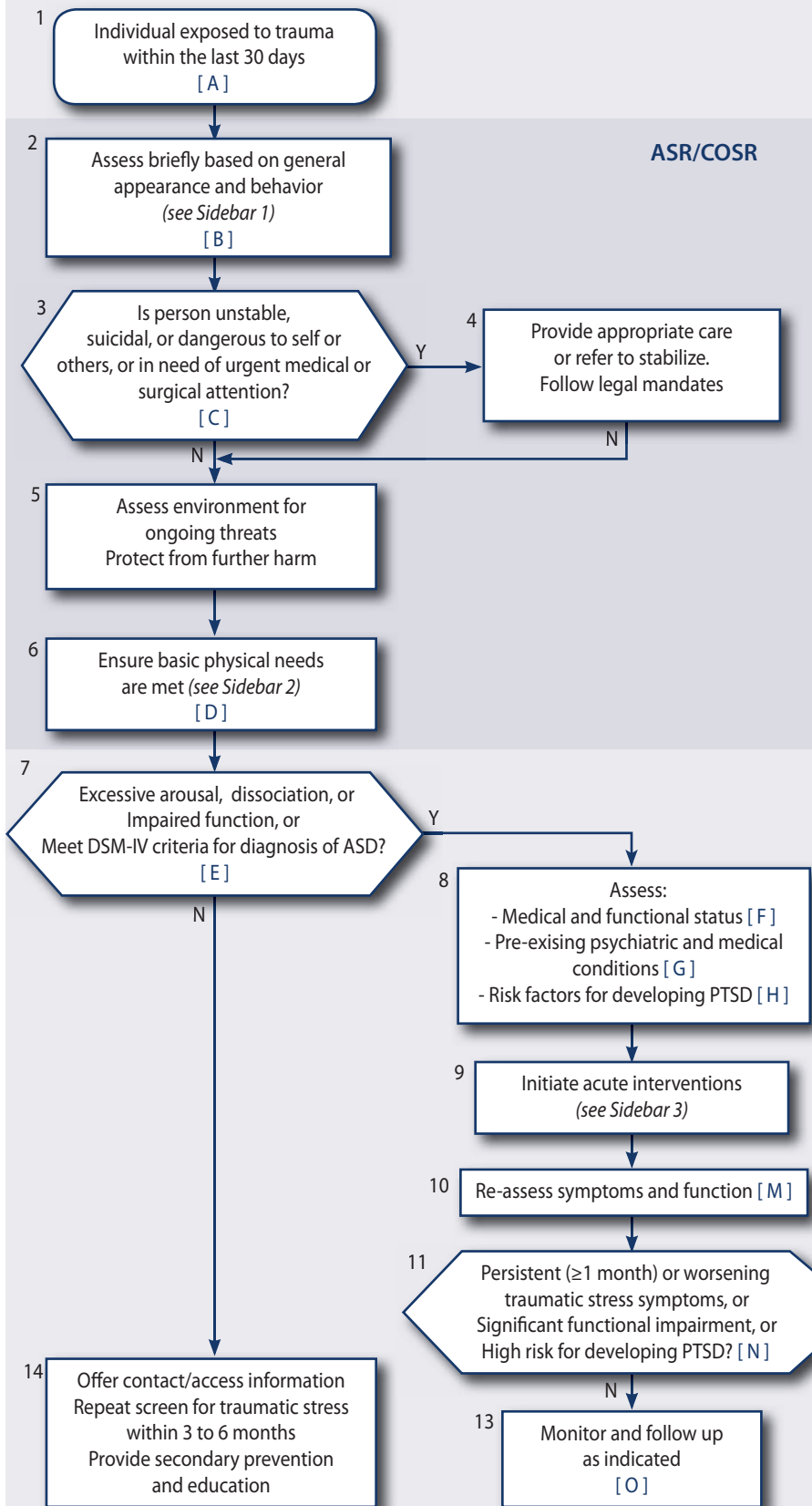
The first **Module (A)** of the guideline, following the Core Module, incorporates the assessment and management of symptoms of **Acute Stress Reaction (ASR)** in the immediate period after exposure to trauma. The goal of interventions is to provide trauma survivors with assistance in addressing immediate physical needs, social and spiritual support, normalization, and Psychological First Aid following trauma.

The approach to triage in the immediate response to traumatic exposure for service members during **Combat or Ongoing Military Operation (COSR)** is directed by dual sets of objectives: context and setting of care delivery may vary markedly.

**Module B** includes the assessment and management of patients diagnosed with **Post-Traumatic Stress Disorder (PTSD)** in the acute or chronic state and potential co-occurring disorders.

# ALGORITHM A

# ACUTE STRESS REACTION/DISORDER (ASR/ASD)



### Sidebar 1. Assessment

- Symptoms
- Trauma
- Risk factors
- Medical status
- Mental status
- Functional status
- Psychosocial status
- Dangerousness
- Unit disruption

### Sidebar 2. Immediate Needs

- Survival
- Safety & Security
- Food, hydration
- Shelter, clothing
- Sleep
- Medical care (first aid)
- Stabilization (if needed)
- Orientation
- Communication with unit/family, friends and community

### Sidebar 3. Acute Interventions

**Provide:**

- Education & normalization [I]
- Brief sessions psychotherapy with exposure and/or cognitive restructuring components [J]
- Acute symptom management: [K]
  - Sleep disturbance
  - Hyperarousal
  - Pain
- Social & spiritual support [L]

**Avoid:**

- Individual and group psychological debriefing [J]

## ANNOTATIONS

### 1. ASSESSMENT

#### *Annotation A. Trauma Exposure (within the past 30 days)*

**Acute Stress Reaction (ASR)** is a transient condition that often develops in response to a traumatic event. Traumatic events are events that cause a person to fear that he/she may die or be seriously injured or harmed. These events also can be traumatic when the person witnesses them happening to others. Such events often create feelings of intense fear, helplessness, or horror for those who experience them. The traumatic events that can lead to an acute stress reaction are of similar severity to those involved in Post-Traumatic Stress Disorder (PTSD).

**Combat or Operational Stress Reaction (COSR)** is an acute stress reaction of service members during ongoing military operations. COSR specifically refers to a reaction to high-stress events and potentially traumatic event exposure. This reaction is not attributed to an identified medical/surgical condition that requires other urgent treatment (a service member can have COSR concurrent with minor wounds/illnesses).

Among the common types of traumatic events are:

- Combat in a war zone
- Ongoing military operations
- Rape, sexual, or other physical assault
- Natural disaster (e.g., hurricanes, floods, or fires)
- Child physical and/or sexual abuse
- Domestic violence (battering)
- Motor vehicle accidents (MVAs)
- Exposure to the sudden or unexpected death of others
- Sudden life-threatening physical illness (e.g., heart attack or cancer)
- Continuous or reoccurring exposure to traumatic event(s).

Events specific to COSR:

- Intense emotional demands (e.g., rescue personnel and caregivers searching for possibly dying survivors or interacting with bereaved family members)
- Extreme fatigue, weather exposure, hunger, sleep deprivation
- Extended exposure to danger, loss, emotional/physical strain
- Exposure to environmental hazards, such as toxic contamination (e.g., gas or fumes, chemicals, radioactivity)
- While a COSR can result from a specific traumatic event, it generally emerges from cumulative exposure to multiple stressors.

Onset of at least some signs and symptoms may be simultaneous with the trauma itself or may follow the trauma after an interval of hours or days. Symptoms may include depression, fatigue, anxiety, decreased concentration/memory, irritability, agitation, and exaggerated startle response.

### ***Annotation B. Assess Briefly Based on General Appearance and Behavior***

1. Identification of a patient with ASR symptoms is based on observation of behavior and function; there is insufficient evidence to recommend a specific screening tool.
2. Individuals exhibiting the following responses to trauma should be screened for ASR:
  - a. Physical: exhaustion, hyperarousal, somatic complaints (GI, GU, MS, CV, Respiratory, NS), or symptoms of conversion disorder
  - b. Emotional: anxiety, depression, guilt/hopelessness
  - c. Cognitive/mental: amnesic or dissociative symptoms, hyper-vigilance, paranoia, intrusive re-experiencing
  - d. Behavioral: avoidance, problematic substance use.
3. Individuals who experience ASR should receive a comprehensive assessment of their symptoms to include details about the time of onset, frequency, course, severity, level of distress, functional impairment, and other relevant information.
4. Assess for capability to perform routine functions.

#### ***Assessment specific to COSR:***

5. Assess service member's functional status, to include:
  - a. Any changes in productivity
  - b. Co-worker or supervisor reports of recent changes in appearance, quality of work, or relationships
  - c. Any tardiness/unreliability, loss of motivation, or loss of interest
  - d. Forgetful or easily distracted
  - e. Screening for substance use.
6. Document symptoms of COSR and obtain collateral information from unit leaders, coworkers, or peers about stressors, function, medical history, and absence or impairment in operation or mission.
7. Consider the service member's role and functional capabilities and the complexity and importance of his/her job.

### ***Annotation C. Unstable, Dangerous to Self or Others, or Need for Urgent Medical Attention***

1. Address acute medical/behavioral issues to preserve life and avoid further harm by:
  - a. Providing appropriate medical/surgical care or referring to stabilize
  - b. Evaluating the use of prescribed medications
  - c. Preventing possible biological or chemical agent exposure
  - d. Managing substance intoxication or withdrawal
  - e. Stopping self-injury or mutilation
  - f. Addressing inability to care for oneself.
2. Arrange a safe, private, and comfortable environment for continuation of the evaluation:
  - a. Assess danger to self or others (e.g., suicidal, or homicidal behavior)
  - b. Establish a working treatment alliance with the patient
  - c. Maintain a supportive, non-blaming, non-judgmental stance throughout the evaluation

- d. Assist with the removal of any ongoing exposure to stimuli associated with the traumatic event
  - e. Minimize further traumas that may arise from the initial traumatic event
  - f. Assess and optimize social supports
  - g. Secure any weapons and explosives.
3. Legal mandates should be followed:
    - a. Reporting of violence, assault
    - b. Confidentiality for the patient
    - c. Mandatory testing
    - d. Attending to chain of evidence in criminal cases (e.g., rape, evaluation)
    - e. Involuntary Commitment procedures if needed.
  4. Carefully consider the following potential interventions to secure safety:
    - a. Find safe accommodation and protect against further trauma
    - b. Voluntary admission if suicidal
    - c. Restraint/seclusion only if less restrictive measures are ineffective
    - d. Provide medications managing specific symptoms as needed (e.g., sleep, pain).
  5. Educate and “normalize” observed psychological reactions to the chain of command.
  6. Evacuate to next level of care if unmanageable, if existing resources are unavailable, or if reaction is outside of the scope of expertise of the care provider.

#### ***Annotation D. Ensure Basic Physical Needs Are Met***

1. Acute intervention should ensure that the following needs are met:
  - a. Safety/security/survival
  - b. Food, hydration, clothing, hygiene, and shelter
  - c. Sleep
  - d. Medications (i.e., replace medications destroyed/lost)
  - e. Education as to current status
  - f. Communication with family, friends, and community
  - g. Protection from ongoing threats/toxins/harm. If indicated, reduce use of alcohol, tobacco, caffeine, and illicit psychoactive substances.
2. Provide Psychological First Aid to:
  - a. Protect survivors from further harm
  - b. Reduce physiological arousal
  - c. Mobilize support for those who are most distressed
  - d. Keep families together and facilitate reunion with loved ones
  - e. Provide information and foster communication and education
  - f. Use effective risk communication techniques.

#### ***Interventions Specific for Members of Pre-existing Group (e.g., COSR):***

3. Treat according to member’s prior role and not as a “patient.”
4. Assure or provide the following, as needed:
  - a. Reunion or ongoing contact with group/unit
  - b. Promote continuity with established relationships (e.g., primary group)

- c. Respite from intense stress
- d. Comfortable environment (e.g., thermal comfort)
- e. Consider psychoeducation and discussion in a group format
- f. Assign job tasks and recreational activities that will restore focus and confidence and reinforce teamwork (limited duty).

**Table A-1. Key Elements of Psychological First Aid (PFA)**

- a. Contact and Engagement - Respond to contacts initiated by affected persons, or initiate contacts in a non-intrusive, compassionate, and helpful manner
- b. Safety and Comfort - Enhance immediate and ongoing safety, and provide physical and emotional comfort
- c. Stabilization (if needed) - Calm and orient emotionally overwhelmed or distraught survivors
- d. Information Gathering - Current Needs and Concerns - Identify immediate needs and concerns, gather additional information, and tailor PFA interventions
- e. Practical Assistance - Offer practical help to the survivor in addressing immediate needs and concerns
- f. Connection with Social Supports - Help establish opportunities for brief or ongoing contacts with primary support persons or other sources of support, including family members, friends, and community helping resources
- g. Information on Coping - Provide information (about stress reactions and coping) to reduce distress and promote adaptive functioning
- h. Linkage to Collaborative Services - Link survivors with needed services and inform them about available services that may be needed in the future.

These core goals of PFA constitute the basic objectives of providing early assistance (e.g., within days or weeks following an event). The amount of time spent on each goal will vary from person to person, and with different circumstances according to need. The complete document describing PFA components can be found at: <http://www.vdh.state.va.us/EPR/pdf/PFA9-6-05Final.pdf>

**Table A-2. Early Interventions after Exposure to Trauma (<4 days after exposure)**

SR	Effect = Balance of Benefit and Harm			
	Significant Benefit	Some Benefit	Unknown Benefit	No Benefit Potential Harm
I	--	<ul style="list-style-type: none"> <li>• Psychological First Aid</li> <li>• Psychoeducation and normalization</li> <li>• Social support</li> </ul>	<ul style="list-style-type: none"> <li>• Spiritual support</li> </ul>	--
D	--	--	--	<ul style="list-style-type: none"> <li>• Psychological debriefing</li> </ul>

SR = Strength of recommendation (see Introduction)



***Annotation E. Person Has Trauma Related Symptoms, Significant Impaired Function, or Diagnosis of ASD***

1. Acutely traumatized people, who meet the criteria for diagnosis of ASD, and those with significant levels of post-trauma symptoms after at least two weeks post-trauma, as well as those who are incapacitated by acute psychological or physical symptoms, should receive further assessment and early intervention to prevent PTSD.
2. Trauma survivors, who present with symptoms that do not meet the diagnostic threshold for ASD, or those who have recovered from the trauma and currently show no symptoms, should be monitored and may benefit from follow-up and provision of ongoing counseling or symptomatic treatment.
3. Service members with COSR who do not respond to initial supportive interventions may warrant referral or evacuation.

***Annotation F. Assess Medical and Functional Status***

1. Medical status should be obtained for all persons presenting with symptoms to include:
  - a. History, physical examination, and a neurological examination
  - b. Use of prescribed medications, mood or mind-altering substances, and possible biological or chemical agent exposure
  - c. A mini-mental status examination (MMSE) to assess cognitive function if indicated.
2. The history and physical examination findings should lead the provider to other assessments as clinically indicated. Based on the clinical presentation, assessment may include:
  - a. Screen for toxicology if the symptom presentation indicates
  - b. Radiological assessment of patients with focal neurological findings or possible head injury
  - c. Appropriate laboratory studies to rule out medical disorders that may cause symptoms of acute stress reactions (e.g., complete blood count [CBC], chemistry profile, thyroid studies, HCG, EKG, EEG).
3. A focused psychosocial assessment should be performed to include assessment of active stressors, losses, current social supports, and basic needs (e.g., housing, food, and financial resources).
4. A brief assessment of function should be completed to evaluate: 1) objectively impaired function based on general appearance and behavior; 2) subjectively impaired function; 3) baseline level of function (LOF) vs. current LOF; and 4) family and relationship functioning.

***Annotation G. Assess Pre-Existing Psychiatric and Medical Conditions***

1. Assess patients for pre-existing psychiatric conditions to identify high-risk individuals and groups.
2. Assure access and adherence to medications that the patient is currently taking.
3. Refer patients with pre-existing psychiatric conditions to mental health specialty when indicated or emergency hospitalization if needed.

## ***Annotation H. Assess Risk Factors for Developing ASD/PTSD***

1. Trauma survivors who exhibit symptoms or functional impairment should be screened for the following risk factors for developing ASD/PTSD:

### ***Pre-traumatic factors***

1. Ongoing life stress
2. Lack of social support
3. Young age at time of trauma
4. Pre-existing psychiatric disorders or substance misuse
5. History of traumatic events (e.g., MVA)
6. History of post-traumatic stress disorder (PTSD)
7. Other pre-traumatic factors, including: female gender, low socioeconomic status, lower level of education, lower level of intelligence, race (e.g., Hispanic, African-American, American Indian, and Pacific Islander), reported abuse in childhood, report of other previous traumatization, report of other adverse childhood factors, family history of psychiatric disorders, and poor training or preparation for the traumatic event.

### ***Peri-traumatic or trauma related factors***

1. Severe trauma
2. Physical injury to self or other
3. Type of trauma (combat, interpersonal traumas, such as killing another person, torture, rape, or assault, convey high risk of PTSD)
4. High perceived threat to life of self or others
5. Community (mass) trauma
6. Other peri-traumatic factors, including: history of peri-traumatic dissociation and interpersonal trauma.

### ***Post-traumatic factors***

1. Ongoing life stress
2. Lack of positive social support
3. Bereavement or traumatic grief
4. Major loss of resources
5. Negative social support (shaming or blaming environment)
6. Poor coping skills
7. Other post-traumatic factors, including: children at home and/or a distressed spouse.

## 2. TREATMENT

### *Annotation I. Provide Education and Normalization / Expectancy of Recovery*

1. All survivors should be given educational information to help normalize common reactions to trauma, improve coping, enhance self-care, facilitate recognition of significant problems, and increase knowledge of and access to services. Such information can be delivered in many ways, including public media, community education activities, and written materials.

### *Annotation J. Initiate Brief Intervention*

The following treatment recommendations should apply for all acutely traumatized people who meet the criteria for diagnosis of ASD, and for those with significant levels of acute stress symptoms that last for more than two weeks post-trauma, as well as those who are incapacitated by acute psychological or physical symptoms.

1. Continue providing psychoeducation and normalization.
2. Treatment should be initiated after education, normalization, and Psychological First Aid has been provided and after basic needs following the trauma have been made available.
3. There is insufficient evidence to recommend for or against the use of Psychological First Aid to address symptoms beyond 4 days following trauma. [I]
4. Survivors who present with symptoms that do not meet the diagnostic threshold of ASD or PTSD should be monitored and may benefit from follow-up and provision of ongoing counseling or symptomatic treatment.
5. Recommend monitoring for development of PTSD using validated symptom measures (e.g., PTSD Checklist, other screening tools for ASD/PTSD).
6. **Psychotherapy:**
  - a. Consider early brief intervention (4 to 5 sessions) of cognitive-based therapy (CBT) that includes exposure-based therapy, alone or combined with a component of cognitive re-structuring therapy for patients with significant early symptom levels, especially those meeting diagnostic criteria for ASD. [A]
  - b. Routine formal psychotherapy intervention for *asymptomatic* individuals is not beneficial and may be harmful. [D]
  - c. Strongly recommend against individual Psychological Debriefing as a viable means of reducing acute stress disorder (ASD) or progression to post-traumatic stress disorder (PTSD). [D]
  - d. The evidence does not support a single session group Psychological Debriefing as a viable means of reducing acute stress disorder (ASD) or progression to post-traumatic stress disorder (PTSD), but there is no evidence of harm (Note: this is not a recommendation pertaining to Operational Debriefing). [D]
  - e. Groups may be effective vehicles for providing trauma-related education, training in coping skills, and increasing social support, especially in the context of multiple group sessions. [I]
  - f. Group participation should be voluntary.

**7. Pharmacotherapy:**

- a. There is no evidence to support a recommendation for use of a pharmacological agent to prevent the development of ASD or PTSD. [I]
- b. Strongly recommend against the use of benzodiazepines to prevent the development of ASD or PTSD. [D]

**Table A-3. Early Interventions after Exposure to Trauma (4 to 30 days after exposure)**

Effect = Balance of Benefit and Harm				
SR	Significant Benefit	Some Benefit	Unknown Benefit	No Benefit
A	<ul style="list-style-type: none"> <li>• Brief Cognitive Behavioral Therapy (4-5 sessions)</li> </ul>	--	--	--
B	--	--	--	--
C	--	<ul style="list-style-type: none"> <li>• Social support</li> </ul>	--	--
D	--	--	--	<ul style="list-style-type: none"> <li>• Individual psychological debriefing *</li> <li>• Formal psychotherapy for asymptomatic survivors *</li> <li>• Benzodiazepines *</li> <li>• Typical Antipsychotics *</li> </ul>
I	--	<ul style="list-style-type: none"> <li>• Psychoeducation and normalization</li> </ul>	<ul style="list-style-type: none"> <li>• Imipramine</li> <li>• Propranolol</li> <li>• Prazosin</li> <li>• Other Antidepressants</li> <li>• Anticonvulsants</li> <li>• Atypical Antipsychotics</li> <li>• Spiritual support</li> <li>• Psychological First Aid</li> </ul>	<ul style="list-style-type: none"> <li>• Group psychological debriefing</li> </ul>

SR = Strength of recommendation (see Introduction); \* Potential harm

**Annotation K. Acute Symptom Management**  
(See Section I-3: Symptom Management)

1. Symptom-specific treatment should be provided after education, normalization, and basic needs are met.
2. Consider a short course of medication (less than 6 days), targeted for specific symptoms in patients post-trauma
  - a. Sleep disturbance/insomnia
  - b. Management of pain
  - c. Irritation/excessive arousal/anger.
3. Provide non-pharmacological interventions to address specific symptoms (e.g., relaxation, breathing techniques, avoiding caffeine) and to address both general recovery and specific symptoms (sleep disturbance, pain, hyper-arousal, or anger).

**L-1 Facilitate Spiritual Support**

1. Ensure patient access to spiritual care when sought.
2. Assess for spiritual needs.
3. Provide opportunities for grieving for losses (providing space and opportunities for prayers, mantras, rites, rituals, and end-of-life care, as determined important by the patient).

**L-2 Facilitate Social Support**

1. Immediately after trauma exposure, preserve an interpersonal safety zone protecting basic personal space (e.g., privacy, quiet, personal effects).
2. As part of Psychological First Aid, reconnect trauma survivors with previously supportive relationships (e.g., family, friends, and unit members) and link with additional sources of interpersonal support.
3. Assess for impact of PTSD on social functioning.
4. Facilitate access to social support and provide assistance in improving social functioning, as indicated.

### 3. REASSESSMENT

#### *Annotation M. Reassess Symptoms and Function*

1. Assessment of the response to the acute intervention should include an evaluation for the following risk factors:
  - a. Persistent or worsening traumatic stress symptoms (e.g., dissociation, panic, autonomic arousal, cognitive impairment)
  - b. Significant functional impairments (e.g., role/work relationships)
  - c. Dangerousness (suicidal or violent ideation, plan, and/or intent)
  - d. Severe psychiatric co-morbidity (e.g., psychotic spectrum disorder, substance use disorder or abuse)
  - e. Maladaptive coping strategies (e.g., pattern of impulsivity, social withdrawal, or other reactions under stress)
  - f. New or evolving psychosocial stressors
  - g. Poor social supports.
2. Follow-up after acute intervention to determine patient status should include the following:
  - a. Patient does not improve or status worsens – continue management of PTSD (see Module B) in consultation or referral to PTSD specialty care or mental health provider. Recommend involvement of the primary care provider in the treatment. Patients with multiple problems may benefit from a multi-disciplinary approach to include occupational therapy, spiritual counseling, recreation therapy, social work, psychology, and/or psychiatry.
  - b. Patient demonstrates partial improvement (e.g., less arousal, but no improvement in sleep) – consider augmentation or adjustment of the acute intervention and follow up within 2 weeks.
  - c. Patient recovers from acute symptoms – provide education about acute stress reaction and contact information with instructions for available follow-up if needed.

## 4. FOLLOW-UP

### *Annotation N. Persistent (>1 Month) or Worsening Symptoms, Significant Functional Impairment, or High Risk for Development of PTSD*

1. Individuals who fail to respond to early interventions should be referred for PTSD treatment when they have:
  - a. Worsening of stress-related symptoms
  - b. High potential or new onset of potential for dangerousness
  - c. Development of ASD/PTSD
  - d. Maladaptive coping with stress (e.g., social withdrawal, alcohol use)
  - e. Exacerbation of pre-existing psychiatric conditions
  - f. Deterioration in function
  - g. New onset stressors
  - h. Poor social supports.
2. Primary Care provider should consider initiating therapy pending referral or if the patient is reluctant or unable to obtain specialty services.
3. Primary Care provider should continue evaluating and treating co-morbid somatic illnesses, and addressing any other health concerns, as well as educating and validating the patient regarding his/her illness.

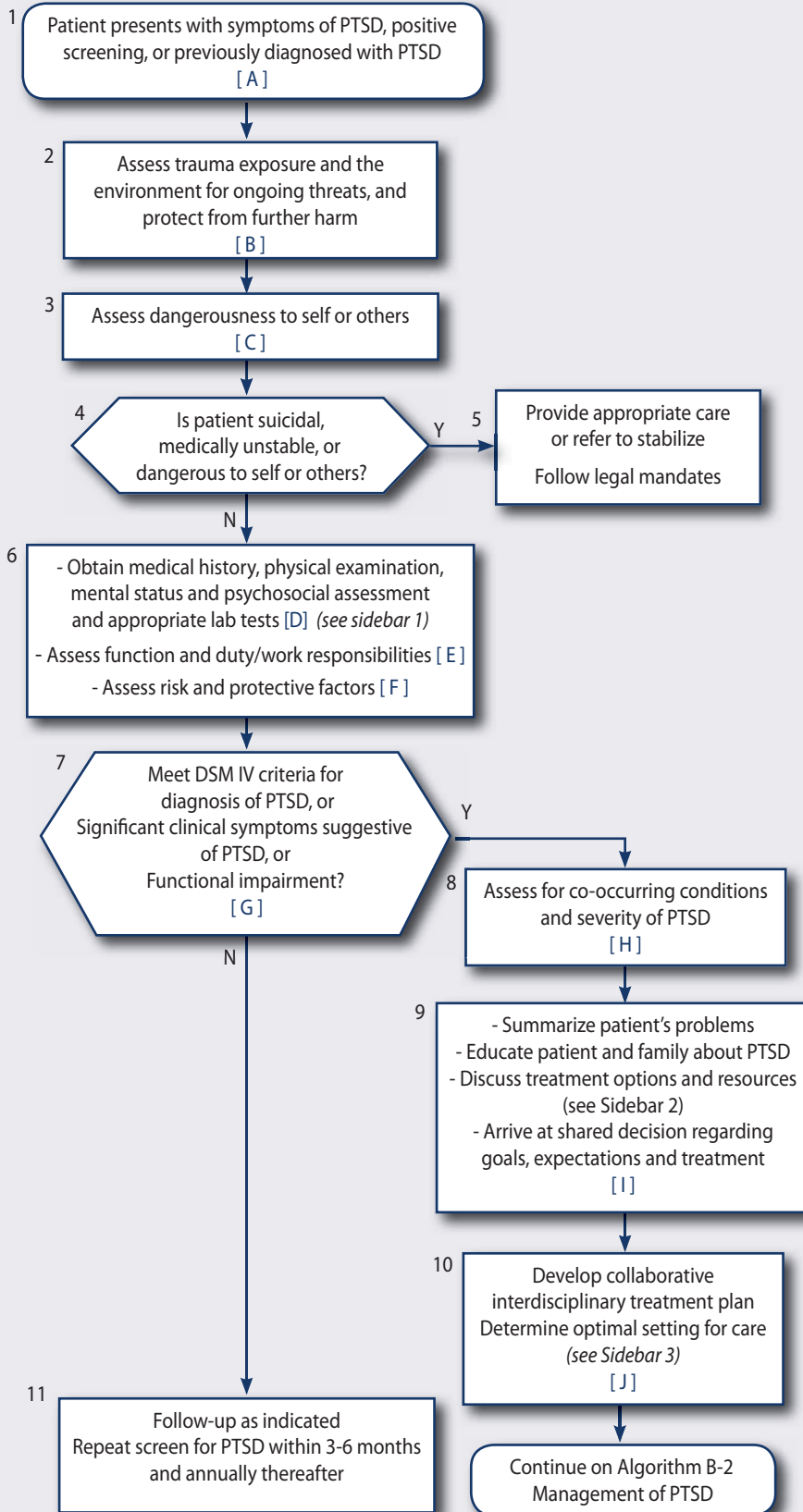
### *Annotation O. Monitor and Follow-Up*

1. Follow-up should be offered to individuals who request it, or those at high risk of developing adjustment difficulties following exposure to major incidents and disasters, including individuals who:
  - Have acute stress disorder or other clinically-significant symptoms stemming from the trauma
  - Are bereaved
  - Have a pre-existing psychiatric disorder
  - Require medical or surgical attention
  - Were exposed to a major incident or disaster that was particularly intense and of long duration.
2. Primary Care providers should follow-up with patients about issues related to trauma in an ongoing way. Patients with initial sub-threshold presentation are at increased risk of developing PTSD and may need symptom-specific management.



# ALGORITHM B-1

# ASSESSMENT AND DIAGNOSIS OF PTSD



### Sidebar 1: Assessment

- History: psychiatric, medical, military, marital, family, past physical or sexual abuse, medication or substance abuse, social and spiritual life
- Identify trauma history and duration
- Drug inventory (including over-the-counter drugs and herbals)
- Corroborate evaluation with family/significant other
- Physical exam and laboratory tests - evidence of trauma
- Assess for signs of trauma, substance use, or co-morbidity
- Assess and assure safety of self and others [D]

### Sidebar 2: Treatment Setting Considerations

- Existence of co-occurring disorders
- Severity of co-morbid conditions
- Severity of PTSD symptoms
- Expertise of the provider
- Patient preferences
- Continuity of care (mental health, primary care, integrated care, Vet centers, other)
- Resource availability (e.g., transportation) [J]

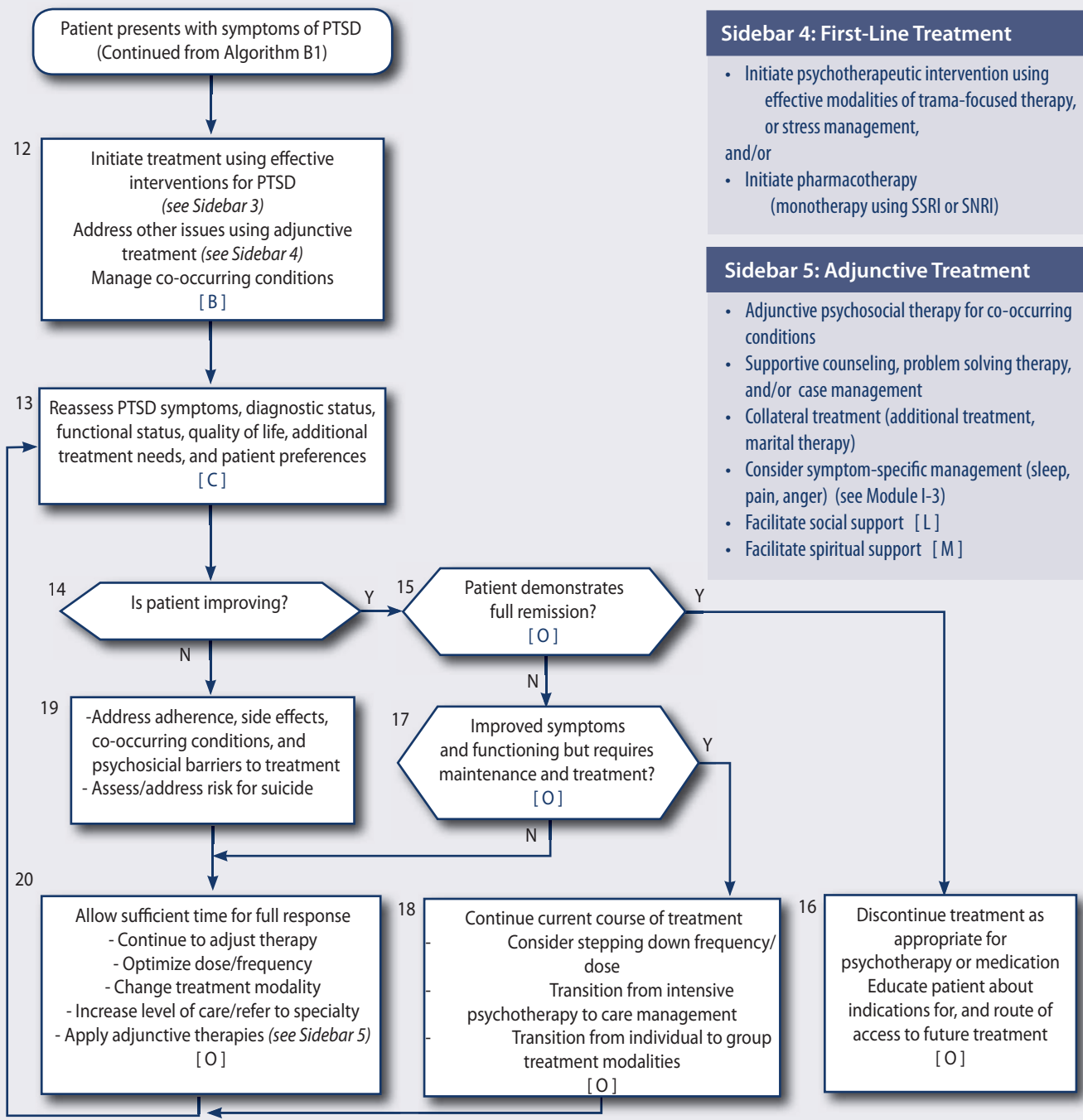
### Sidebar 3: Indication for Referral to Specialty Care

- Severe or unstable co-occurring conditions
- Severe or unstable PTSD
- Patient prefers referral to specialty [J]

Primary care clinicians may decide to refer for specialized psychiatric care at any point, depending on comfort and experience in treating PTSD

# ALGORITHM B-2

# TREATMENT FOR PTSD



### Sidebar 4: First-Line Treatment

- Initiate psychotherapeutic intervention using effective modalities of trauma-focused therapy, or stress management, and/or
- Initiate pharmacotherapy (monotherapy using SSRI or SNRI)

### Sidebar 5: Adjunctive Treatment

- Adjunctive psychosocial therapy for co-occurring conditions
- Supportive counseling, problem solving therapy, and/or case management
- Collateral treatment (additional treatment, marital therapy)
- Consider symptom-specific management (sleep, pain, anger) (see Module I-3)
- Facilitate social support [L]
- Facilitate spiritual support [M]

### Stepped Care Treatment of PTSD

Initial Treatment	Step I	Step II	Step III
Psychotherapy or SSRI or SNRI	Switch to another SSRI or SNRI and/or psychotherapy	Add psychotherapy, and/or switch to mirtazapine	Switch to alternative Step II or to TCA, or nefazadone, or phenelzine Add psychotherapy

## MODULE B: MANAGEMENT OF PTSD

### ANNOTATIONS

#### 1. ASSESSMENT

##### *Annotation A. Assessment of Trauma Exposure Related Symptoms*

1. Patients who are presumed to have symptoms of PTSD or who are positive for PTSD on the initial screening should receive a thorough assessment of their symptoms that includes details such as time of onset, frequency, course, severity, level of distress, functional impairment, and other relevant information to guide accurate diagnosis and appropriate clinical decision-making.
2. Consider use of a validated, self-administered checklist to ensure systematic, standardized, and efficient review of the patient's symptoms and history of trauma exposure. Routine ongoing use of these checklists may allow assessment of treatment response and patient progress.
3. Diagnosis of PTSD should be obtained based on a comprehensive clinical interview that assesses all the symptoms that characterize PTSD. Structured diagnostic interviews, such as the Clinician-Administered PTSD scale (CAPS), may be considered.

**Table A-1. Common Symptoms following Exposure to Trauma**

Physical	Cognitive/Mental	Emotional	Behavioral
<ul style="list-style-type: none"> <li>• Chills</li> <li>• Difficulty breathing</li> <li>• Dizziness</li> <li>• Elevated blood pressure</li> <li>• Fainting</li> <li>• Fatigue</li> <li>• Grinding teeth</li> <li>• Headaches</li> <li>• Muscle tremors</li> <li>• Nausea</li> <li>• Pain</li> <li>• Profuse sweating</li> <li>• Rapid heart rate</li> <li>• Twitches</li> <li>• Weakness</li> </ul>	<ul style="list-style-type: none"> <li>• Blaming someone</li> <li>• Change in alertness</li> <li>• Confusion</li> <li>• Hyper-vigilance</li> <li>• Increased or decreased awareness of surroundings</li> <li>• Intrusive images</li> <li>• Memory problems</li> <li>• Nightmares</li> <li>• Poor abstract thinking</li> <li>• Poor attention</li> <li>• Poor concentration</li> <li>• Poor decision-making</li> <li>• Poor problem solving</li> </ul>	<ul style="list-style-type: none"> <li>• Agitation</li> <li>• Anxiety</li> <li>• Apprehension</li> <li>• Denial</li> <li>• Depression</li> <li>• Emotional shock</li> <li>• Fear</li> <li>• Feeling overwhelmed</li> <li>• Grief</li> <li>• Guilt</li> <li>• Inappropriate emotional response</li> <li>• Irritability</li> <li>• Loss of emotional control</li> </ul>	<ul style="list-style-type: none"> <li>• Increased alcohol consumption</li> <li>• Antisocial acts</li> <li>• Change in activity</li> <li>• Change in communication</li> <li>• Change in sexual functioning</li> <li>• Change in speech pattern</li> <li>• Emotional outbursts</li> <li>• Inability to rest</li> <li>• Change in appetite</li> <li>• Pacing</li> <li>• Startle reflex intensified</li> <li>• Suspiciousness</li> <li>• Social withdrawal</li> </ul>

### *Annotation B. Assessment of Trauma Exposure*

1. Assessment of the trauma exposure experience should include:
  - a. History of exposure to traumatic event(s)
  - b. Nature of the trauma
  - c. Severity of the trauma
  - d. Duration and frequency of the trauma
  - e. Age at time of trauma
  - f. Patient's reactions during and immediately following trauma exposure (e.g., helplessness, horror, and fear)
  - g. Existence of multiple traumas.
2. If trauma exposure is recent (<1 month), particular attention should be given to the following:
  - a. Exposure to/Environment of trauma
  - b. Ongoing traumatic event exposure
  - c. Exposure, perhaps ongoing, to environmental toxins
  - d. Ongoing perceived threat.
3. When assessing trauma exposure, the clinician must consider the patient's ability to tolerate the recounting of traumatic material, since it may increase distress and/or exacerbate PTSD symptoms.

### *Annotation C. Assessment of Dangerousness to Self or Others*

1. All patients with PTSD should be assessed for safety and dangerousness including current risk to self or others, as well as historical patterns of risk:
  - Suicidal or homicidal ideation, intent (plan), means (e.g., weapon, excess medications), history (e.g., violence or suicide attempts), behaviors (e.g., aggression, impulsivity), co-morbidities (substance abuse, medical conditions)
  - Family and social environment – including risks to the family
  - Ongoing health risks or risk-taking behavior
  - Medical/psychiatric co-morbidities or unstable medical conditions
  - Potential to jeopardize mission in an operational environment.

### *Annotation D. Obtain Medical History, Physical Examination, and Laboratory Tests*

1. All patients should have a thorough assessment of medical and psychiatric history, with particular attention paid to the following:
  - a. Baseline functional status
  - b. Baseline mental status
  - c. Medical history: to include any injury (e.g., mild-TBI)
  - d. Medications: to include medication allergies and sensitivities; prescription medications; herbal or nutritional supplements; and over-the-counter (OTC) medications (caffeine, energy drinks or use of other substances)
  - e. Past psychiatric history: to include prior treatment for mental health and substance use disorder, and past hospitalization for depression or suicidality
  - f. Current life stressors.

2. All patients should have a thorough physical examination. On physical examination, particular attention should be paid to the neurological exam and stigmata of physical/sexual abuse, self-mutilation, or medical illness. Note distress caused by, or avoidance of, diagnostic tests/examination procedures.
3. All patients, particularly the elderly, should have a Mental Status Examination (MSE) to include assessment of the following:
  - a. Appearance and behavior
  - b. Language/speech
  - c. Thought process (loose associations, ruminations, obsessions) and content (delusions, illusions and hallucinations)
  - d. Mood (subjective)
  - e. Affect (to include intensity, range, and appropriateness to situation and ideation)
  - f. Level of Consciousness (LOC)
  - g. Cognitive function
  - h. All patients should have routine laboratory tests as clinically indicated, such as TSH, Complete Metabolic Panel, Hepatitis, HIV, and HCG (for females). Also consider CBC, UA, Tox/EtoH panel, and other tests
  - i. Other assessments may be considered (radiology studies, ECG, and EEG), as clinically indicated
  - j. All patients should have a narrative summary of psychosocial assessments to include work/school, family, relationships, housing, legal, financial, unit/community involvement, and recreation, as clinically appropriate.

#### *Annotation E. Assessment of Functioning/ Work Responsibilities and Patient's Fitness*

1. Assessment of function should be obtained through a comprehensive narrative assessment, and the use of standardized, targeted, and validated instruments designed to assess family/relationship, work/school, and/or social functioning.
2. The determination of when to return to work/duty should take into consideration the complexity and importance of the patient's job role and functional capabilities.
3. The continuing presence of symptoms of PTSD should not be considered in itself as sufficient justification for preventing a return to work/duty.

#### *Annotation F. Assessment of Risk /Protective Factors*

1. Patients should be assessed for risk factors for developing PTSD. Special attention should be given to post-traumatic factors (i.e., social support, ongoing stressors, and functional incapacity) that may be modified by intervention.
2. When evaluating risk factors for PTSD, the clinician should keep in mind that PTSD is defined as occurring only after four weeks have elapsed following a traumatic event. PTSD symptoms, however, may not appear until a considerable time has passed—sometimes surfacing years later.

## Risk /Protective Factors for Developing PTSD

### ***Pre-traumatic factors***

- a. Ongoing life stress or demographics
- b. Lack of social support
- c. Young age at time of trauma
- d. Pre-existing psychiatric disorder
- e. Female gender
- f. Low socioeconomic status, lower level of education, lower level of intelligence, race (e.g., Hispanic, African-American, American Indian, and Pacific Islander)
- g. Prior trauma exposure (reported abuse in childhood, report of other previous traumatization, report of other adverse childhood factors)
- h. Family history of psychiatric disorders (genetics).

### ***Peri-traumatic or trauma-related factors***

- a. Severe trauma
- b. Type of trauma (interpersonal traumas, such as torture, rape, or assault, convey a high risk of PTSD)
- c. High perceived threat to life
- d. Community (mass) trauma
- e. Peri-traumatic dissociation.

### ***Post-traumatic factors***

- a. Ongoing life stress
- b. Lack of positive social support
- c. Negative social support (e.g., negative reactions from others)
- d. Bereavement
- e. Major loss of resources
- f. Other post-traumatic factors, including children at home and distressed spouse.

## 2. TRIAGE

### *Annotation G. Diagnosis of PTSD or Clinical Significant Symptoms Suggestive of PTSD*

1. A diagnosis of stress-related disorder consistent with the DSM IV criteria for PTSD should be formulated before initiating treatment.
2. Diagnosis of PTSD should be obtained based on a comprehensive clinical interview that assesses all the symptoms that characterize PTSD. Structured diagnostic interviews, such as the Clinician-Administered PTSD scale (CAPS), may be considered.
3. When a diagnostic work out cannot be completed, primary care providers should consider initiating treatment or referral based on a working diagnosis of stress-related disorder.
4. Patients with difficult or complicated presentation of the psychiatric component should be referred to PTSD specialty care for diagnosis and treatment.
5. Patients with partial or sub-threshold PTSD should be carefully monitored for deterioration of symptoms.

### *Annotation H. Assess for Co-occurring Disorders*

1. Providers should recognize that medical disorders/symptoms, mental health disorders, and psychosocial problems commonly coexist with PTSD and should screen for them during the evaluation and treatment of PTSD.
2. Because of the high prevalence of psychiatric co-morbidities in the PTSD population, screening for depression and other psychiatric disorders is warranted (see also VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder and for Bipolar Disorder).
3. Patterns of current and past use of substance by persons with trauma histories or PTSD should be routinely assessed to identify substance misuse or dependency (alcohol, nicotine, prescribed drugs, and illicit drugs) (see also VA/DoD Clinical Practice Guideline for Substance Use Disorders).
4. Pain (acute and chronic) and sleep disturbances should be assessed in all patients with PTSD.
5. Generalized physical and cognitive health symptoms - also attributed to concussion/mild traumatic brain injury (mTBI) and many other causes - should be assessed and managed in patients with PTSD and co-occurring diagnosis of mTBI (see also VA/DoD CPGs for Concussion/mild-TBI, and for Post-Deployment Health).
6. Associated high-risk behaviors (e.g., smoking, alcohol/drug abuse, unsafe weapon storage, dangerous driving, and HIV and hepatitis risks) should be assessed in patients with PTSD.
7. Providers should consider the existence of co-morbid conditions when deciding whether to treat patients in the primary care setting or refer them for specialty mental health care (see [Annotation J](#)).
8. Patients with complicated co-morbidity may be referred to mental health or PTSD specialty care for evaluation and diagnosis (see [Annotation J](#)).



### ***Annotation I. Educate Patient and Family***

1. Trauma survivors and their families should be educated about PTSD symptoms, other potential consequences of exposure to traumatic stress, practical ways of coping with traumatic stress symptoms, co-morbidity with other medical health concerns, processes of recovery from PTSD, and the nature of treatments. [C]
2. Providers should explain to all patients with PTSD the range of available and effective options for PTSD treatment.
3. Patient preferences along with provider recommendations should drive the selection of treatment interventions in a shared and informed decision-making process.

### ***Annotation J. Determine Optimal Setting for Management of PTSD and Co-occurring Disorders***

#### **J-1 Management of PTSD with Co-morbidity**

##### ***Consultation / Referral***

1. PTSD and co-morbid mental health conditions should be treated concurrently for all conditions through an integrated treatment approach, which considers patient preferences, provider experience, severity of the conditions, and the availability of resources.
2. Patients with PTSD and severe co-morbid mental health conditions should be treated either through referral or in consultation with a provider that is experienced in treating the co-morbid conditions.
3. Because of the profound social impairment of PTSD (caused, for example, by the patient's anger and avoidance symptoms), close friends and family members in the patient's immediate daily environment (e.g., parents, spouse, or children) should be provided education and advised to consider assistance from specialty care, both for individual treatment and couples/family treatment.
4. Factors to consider when determining the optimal setting for treatment include:
  - a. Severity of the PTSD or co-occurring disorders
  - b. Local availability of service options (specialized PTSD programs, evidence-based treatments, behavioral health specialty care, primary care, integrated care for co-occurring disorders, Vet Centers, other)
  - c. Level of provider comfort and experience in treating psychiatric co-morbidities
  - d. Patient preferences
  - e. The need to maintain a coordinated continuum of care for chronic co-morbidities
  - f. Availability of resources and time to offer treatment.
5. Considerations related to possible referral:

*Complicated severe PTSD:* Some patients with PTSD have complicated, challenging presentations. These patients warrant referral to specialty PTSD care that includes access to cognitive-behavioral evidence-based treatments (see [Module I-2: Treatment for PTSD](#)).

*Co-occurring major depressive disorder* in the absence of significant suicidality, panic, or generalized anxiety often shows reduction in intensity when the PTSD is treated. Depression of mild severity may not require referral to specialty care or additional treatments outside those targeting PTSD. Patients should be carefully monitored for changes in symptoms. A reduction of PTSD symptoms that is not accompanied by reduction of symptoms in depression or anxiety would justify a more formally targeted treatment (refer to the VA/DoD guideline for Major Depressive Disorder).

*Co-occurring mild to moderate disorders, such as substance use, pain disorders, and sleep problems, can frequently be effectively treated in the context of PTSD treatment and do not require a referral to specialty care. Consultation, to integrate adjunctive interventions, may be considered (see the respective VA/DoD CPGs).*

*Co-occurring severe psychiatric disorders, while not precluding concurrent PTSD treatment, typically justify referral to specialty care for evaluation and treatment. These disorders may include: Severe Major Depression or Major Depression with suicidality, Unstable Bipolar Disorder, Severe Personality Disorders, Psychotic Disorders, Significant TBI, and Severe Substance Use Disorder or substance abuse of such intensity that PTSD treatment components are likely to be difficult to implement.*

*Persistent post-concussion symptoms in patients who present with PTSD and a history of concussion/mTBI may be best managed within the primary care or rehabilitation setting without specialty referral, provided that the provider has a reasonable level of comfort with this topic. Providers should recognize that mTBI/concussion is one of numerous possible etiologies of co-morbid post-deployment symptoms occurring in Veterans and Service Members with PTSD, and it is often difficult to precisely attribute symptoms to concussive events that occurred months or years earlier. From a treatment standpoint, physical or cognitive symptoms, such as headaches or memory problems, can be treated symptomatically whether or not their underlying cause is PTSD, concussion/mTBI, or another condition. Clinicians should not get caught up in debating causation but maintain focus on identifying and treating the symptoms that are causing the most impairment, regardless of the cause. There is no evidence to support withholding other important treatments (e.g., PTSD treatment) while addressing post-concussive symptoms.*

## **J-2 Management of Concurrent PTSD and Substance Use Disorder (SUD)**

1. All patients diagnosed with PTSD should receive comprehensive assessment for SUD, including nicotine dependence (as recommended by the separate CPG).
2. Recommend and offer cessation treatment to patients with nicotine dependence. [A]
3. Patients with SUD and PTSD should be educated about the relationships between PTSD and substance abuse. The patient's prior treatment experience and preference should be considered since no single intervention approach for the co-morbidity has yet emerged as the treatment of choice.
4. Treat other concurrent substance use disorders consistent with VA/DoD clinical practice guidelines including concurrent pharmacotherapy:
  - a. Addiction-focused pharmacotherapy should be discussed, considered, available and offered, if indicated, for all patients with alcohol dependence and/or opioid dependence
  - b. Once initiated, addiction-focused pharmacotherapy should be monitored for adherence and treatment response.
5. Provide multiple services in the most accessible setting to promote engagement and coordination of care for both conditions. [I]
6. Reassess response to treatment for SUD periodically and systematically, using standardized and valid self report instrument(s) and laboratory tests. Indicators of SUD treatment response include ongoing substance use, craving, side effects of medication, emerging symptoms, etc.
7. There is insufficient evidence to recommend for or against any specific psychosocial approach to addressing PTSD that is co-morbid with SUD. [I]

### **J-3 The Role of Primary Care Practitioner:**

1. Primary care providers should routinely provide the following services for all patients with trauma-related disorders, especially those who are reluctant to seek specialty mental health care:
  - Education about the disorder and importance of not letting stigma and barriers to care interfere with specialty treatment if needed
  - Provision of evidence-based treatment within the primary care setting or through referral
  - Regular follow-up and monitoring of symptoms
  - Regular follow-up and monitoring of co-morbid health concerns.
2. Primary care providers should consider consultation with mental health providers for patients with PTSD who warrant a mental health referral but refuse it or seem reluctant to talk to a mental health provider.
3. Primary care providers should take leadership in providing a collaborative multi-disciplinary treatment approach. Team members may include the primary care providers, mental health specialists, other medical specialists (e.g., neurology, pain management), chaplains, pastors, social workers, occupational or recreational therapists, Vet Center staff members, staff of family support centers, exceptional family member programs, VA benefits counselors, vocational rehabilitation specialists, peer counselors, and others.
4. When an integrated behavioral health clinician is available (e.g., collaborative care model, or Post-Deployment Care clinics) evidence-based treatment should be provided.
5. Primary care providers should continue to be involved in the treatment of patients with acute or chronic stress disorders. All patients with PTSD should have a specific primary care provider assigned to coordinate their overall health care.

### 3. TREATMENT

#### *Annotation K. Initiate Treatment Using Effective Interventions for PTSD*

Many treatment strategies are available to treat stress-related disorders and to relieve the burden of suffering for PTSD patients. Options include pharmacotherapy, psychotherapy, and somatic and alternative interventions. Treatment may be provided by primary care providers or in combination with consultation and referral for specific treatments not available in primary care. Some patients will be referred to PTSD or behavioral health specialty for management.

1. A supportive and collaborative treatment relationship or therapeutic alliance should be developed and maintained with patients with PTSD.
2. Evidence-based psychotherapy and/or evidence-based pharmacotherapy are recommended as first-line treatment options.
3. Specialized PTSD psychotherapies may be augmented by additional problem-specific methods/ services and pharmacotherapy.
4. Consider referral for alternative care modalities (Complementary Alternative Medicine) for patient symptoms, consistent with available resources and resonant with patient belief systems. [See Module I-2]
5. Patients with PTSD who are experiencing clinically significant symptoms, including chronic pain, insomnia, anxiety, should receive symptom-specific management interventions. [See Module I-3]
6. Management of PTSD or related symptoms may be initiated based on a presumptive diagnosis of PTSD. Long-term pharmacotherapy will be coordinated with other intervention.

***For Specific Treatment Modalities, See Module I-2 Treatment Interventions for PTSD.***

***Psychotherapy***

***Pharmacotherapy***

***Adjunctive treatments***

***Somatic Therapy***

***Complimentary Alternative Therapy (CAM)***

#### *Annotation L. Facilitate Spiritual Support*

1. Ensure patient access to spiritual care when sought.
2. Assess for spiritual needs.
3. Provide opportunities for grieving for losses (providing space and opportunities for prayers, mantras, rites, rituals, and end-of-life care, as determined important by the patient).

#### *Annotation M. Facilitate Social Support*

1. Assess for impact of PTSD on social functioning.
2. Facilitate access to social support and provide assistance in improving social functioning, as indicated.

## 4. REASSESSMENT

### *Annotation N. Assess Response to Treatment*

1. At a minimum, providers should perform a brief PTSD symptom assessment at each treatment visit. The use of a validated PTSD symptom measure, such as the PTSD Checklist, should be considered.
2. Comprehensive re-assessment and evaluation of treatment progress should be conducted at least every 90 days, perhaps with greater frequency for those in active treatment, and should include a measure of PTSD symptomatology (e.g., PCL) and strongly consider a measure of Depression symptomatology (e.g., PHQ-9).
3. Other specific areas of treatment focus (e.g., substance abuse) should also be reevaluated and measured by standardized measures of outcome.
4. Assessment of functional impairment should also be made, at a minimum, by asking patients to rate to what extent their symptoms make it difficult to engage in vocational, parental, spousal, familial, or other roles.
5. Consider continued assessment of:
  - Patient preferences
  - Treatment adherence
  - Adverse treatment effects.

### *Annotation O. Follow-Up*

1. If patient does not improve or status worsens, consider one of the following treatment modification options:
  - a. Continue application of the same modality at intensified dose and/or frequency
  - b. Change to a different treatment modality
  - c. Apply adjunctive therapies
  - d. Consider a referral to adjunctive services for treatment of co-morbid disorders or behavioral abnormalities (e.g., homelessness, domestic violence, or aggressive behavior)
  - e. For patient with severe symptoms or coexisting psychiatric problems consider referrals to:
    - Specialized PTSD programs
    - Specialized programs for coexisting problems and conditions
    - Partial psychiatric hospitalization or “day treatment” programs
    - Inpatient psychiatric hospitalization.
2. If patient demonstrates partial (insufficient) remission, consider one of the following treatment modification options:
  - a. Before making any therapeutic change, ensure that “treatment non-response” is not due to any of the following: not keeping psychotherapy appointments, not doing prescribed homework, not taking prescribed medications, still using alcohol or illicit substances, still suffering from ongoing insomnia or chronic pain, experiencing new psychosocial stressors, or overlooked co-morbid medical or psychiatric condition
  - b. Continue the present treatment modality to allow sufficient time for full response
  - c. Continue application of the same modality at intensified dose and/or frequency
  - d. Change to a different treatment modality

- e. Apply adjunctive therapies
  - f. Increase level of care (e.g., referral facility, partial hospitalization, inpatient hospitalization, residential care)
  - g. Consider a referral to adjunctive services for treatment of co-morbid disorders or behavioral abnormalities (e.g., homelessness or domestic violence).
3. If patient demonstrates improved symptoms and functioning but requires maintenance treatment:
    - a. Continue current course of treatment
    - b. Consider stepping down the type, frequency, or dose of therapy
    - c. Consider:
      - Transition from intensive psychotherapy to case management contacts
      - Transition from individual to group treatment modalities
      - Transition to as-needed treatment
    - d. Discuss patient status and need for monitoring with the primary care provider
    - e. Consider a referral to adjunctive services for treatment of co-morbid disorders or behavioral abnormalities (e.g., homelessness or domestic violence).
  4. If patient demonstrates remission from symptoms and there are no indications for further therapy:
    - a. Discontinue treatment
    - b. Educate the patient about indications for and route of future care access
    - c. Monitor by primary care for relapse/exacerbation.
  5. Evaluate psychosocial function and refer for psychosocial rehabilitation, as indicated. Available resources may include: chaplains, pastors, Family Support Centers, Exceptional Family Member Programs, VA benefits counselors, occupational or recreational therapists, Vet Centers, and peer-support groups (see [Module I-2 Interventions D1: Psychosocial Rehabilitation](#)).
  6. Provide case management, as indicated, to address high utilization of medical resources.

# MODULE I : INTERVENTIONS

## ANNOTATIONS

### 1. EARLY INTERVENTIONS TO PREVENT PTSD

Table I- 1.1 Early Interventions after Exposure to Trauma (<4 days after exposure)

Effect = Balance of Benefit and Harm				
SR	Significant Benefit	Some Benefit	Unknown Benefit	No Benefit Potential Harm
I	--	<ul style="list-style-type: none"> <li>Psychological First Aid</li> <li>Psychoeducation and normalization</li> <li>Social support</li> </ul>	<ul style="list-style-type: none"> <li>Spiritual support</li> </ul>	--
D	--	--	--	<ul style="list-style-type: none"> <li>Psychological debriefing</li> </ul>

SR = Strength of recommendation (see Introduction)

Table I-1.2 Early Interventions after Exposure to Trauma (4 to 30 days after exposure)

Effect = Balance of Benefit and Harm				
SR	Significant Benefit	Some Benefit	Unknown Benefit	No Benefit
A	<ul style="list-style-type: none"> <li>Brief Cognitive Behavioral Therapy (4-5 sessions)</li> </ul>	--	--	--
B	--	--	--	--
C	--	<ul style="list-style-type: none"> <li>Social support</li> </ul>	--	--
D	--	--	--	<ul style="list-style-type: none"> <li>Individual psychological debriefing *</li> <li>Formal psychotherapy for asymptomatic survivors *</li> <li>Benzodiazepines *</li> <li>Typical Antipsychotics *</li> </ul>
I	--	<ul style="list-style-type: none"> <li>Psychoeducation and normalization</li> </ul>	<ul style="list-style-type: none"> <li>Imipramine</li> <li>Propranolol</li> <li>Prazosin</li> <li>Other Antidepressants</li> <li>Anticonvulsants</li> <li>Atypical Antipsychotics</li> <li>Spiritual support</li> <li>Psychological First Aid</li> </ul>	<ul style="list-style-type: none"> <li>Group psychological debriefing</li> </ul>

SR = Strength of recommendation (see Introduction); \* Potential harm

## 2. TREATMENT INTERVENTIONS FOR PTSD

### *Annotation A. Selection of Therapy for PTSD*

1. Providers should explain to all patients with PTSD the range of available and effective therapeutic options for PTSD.
2. Patient education is recommended as an element of treatment of PTSD for all patients and the family members. [C]
3. Patient and provider preferences should drive the selection of evidence-based psychotherapy and/or evidence-based pharmacotherapy as the first line treatment.
4. Psychotherapies should be provided by practitioners who have been trained in the particular method of treatment.
5. A collaborative care approach to therapy administration, with case management, may be considered, although supportive evidence is lacking specifically for PTSD.

### *Annotation B. Psychotherapy Interventions for PTSD*

Psychotherapy interventions are aimed at reduction of symptoms severity, improvement of global functioning, and improvement in quality of life and functioning in social and occupational areas. Psychotherapy for PTSD may also have benefits in improving co-morbid physical health conditions, but this is not specifically the focus of treatment.

**Table I-2.1 Psychotherapy Interventions for Treatment of PTSD**

Effect = Balance of Benefit and Harm				
SR	Significant Benefit	Some Benefit	Unknown Benefit	No Benefit
A	<ul style="list-style-type: none"> <li>• <b>Trauma-focused psychotherapy</b> that includes components of exposure and/or cognitive restructuring; or,</li> <li>• <b>Stress inoculation</b> training</li> </ul>	--	--	--
C	--	<ul style="list-style-type: none"> <li>• Patient Education</li> <li>• Imagery Rehearsal Therapy</li> <li>• Psychodynamic Therapy</li> <li>• Hypnosis</li> <li>• Relaxation Techniques</li> <li>• Group Therapy</li> </ul>	--	--
I	--	<ul style="list-style-type: none"> <li>• Family Therapy</li> </ul>	<ul style="list-style-type: none"> <li>• WEB-Based CBT</li> <li>• Acceptance and Commitment Therapy</li> <li>• Dialectical Behavioral Therapy</li> </ul>	--

SR = Strength of Recommendation (see Introduction)



## ***Effective Psychotherapies for PTSD***

There are significant difficulties in categorizing the different evidence-based psychotherapies that have been found to be most effective for PTSD. There are a number of reasons for this difficulty, including the diversity of treatments available, a lack of a common terminology to describe the same treatment components, the specific ways in which similar components are manualized or packaged, and lack of consensus between proponents for specific treatments.

The evidence-based psychotherapeutic interventions for PTSD that are most strongly supported by RCTs can be considered broadly within in the **trauma-focused psychotherapy** category or **stress inoculation training**. Trauma-focused psychotherapies for PTSD refer to a broad range of psychological interventions based on learning theory, cognitive theory, emotional processing theory, fear-conditioning models, and other theories. They include a variety of techniques most commonly involving exposure and/or cognitive restructuring (e.g., Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and Eye Movement Desensitization and Reprocessing (EMDR)). They are often combined with anxiety management/stress reduction skills focused specifically on alleviating the symptoms of PTSD. Psychoeducation is another important component of all interventions. Other Cognitive Behavioral Therapy (CBT) interventions that are not trauma-focused are less effective.

Although, **Stress Inoculation Training** (SIT) does not necessarily focus as explicitly on the exploration of traumatic memories, it is included as a first-line alternative to trauma-focused psychotherapies for treating PTSD. SIT, which was developed originally for anxiety disorders and then modified for rape victims and later for PTSD, has been extensively studied in the treatment of PTSD. It has also been compared head-to-head with trauma-focused psychotherapies, and has been shown to be effective in assisting individuals with reducing trauma-related avoidance, anxiety, and cognitions, and there is good evidence that it is equivalent in efficacy to the trauma-focused psychotherapies.

In formulating the specific recommendations for psychotherapy, the working group evaluated the empirical evidence, considering randomized trials as the highest level of the evidence-based hierarchy. It should be noted that therapy provided in clinical trial settings differs from therapy that is practiced in day-to-day care, and the recommendations represent the techniques and protocols as they were studied and reported in the RCTs.

### ***Packaging of Manualized Approaches of Therapy***

The working group recognized that despite various perspectives on how to categorize the most effective PTSD psychotherapies, all of the modalities supported by level-A evidence likely have overlapping mechanisms of action. Trauma-focused psychotherapies include exposure techniques that involve repetitive review of traumatic memories and trauma-related situations, cognitive techniques that focus on identification and modification of trauma-related beliefs and meanings, and/or stress reduction techniques designed to alleviate PTSD symptoms and assist patients in gaining control and mastery over the physiological reactivity.

SIT protocols that have been tested in clinical trials often include components of cognitive restructuring or in-vivo exposure, and some SIT techniques (e.g. breathing retraining, relaxation) are incorporated into virtually every other trauma-focused psychotherapy that has been studied in RCTs. Consequently, it is difficult to disentangle the relative contribution of SIT techniques in the efficacy of the other trauma-focused psychotherapy treatments.

Components of efficacious interventions for PTSD, studied in clinical trials, have been packaged in various ways. Most RCTs have manualized the techniques to ensure the fidelity of treatment for use by the investigators. Some manualized approaches have gained wide popularity, but there is no evidence that they are any more effective than less accepted protocols that package the core components of trauma-focused therapies in different ways. The core components used in the vast majority of A-level interventions have involved combinations of exposure (particularly in-vivo and imaginal/oral narrative), cognitive restructuring, relaxation/stress modulation techniques, and psychoeducation. Very few studies have dismantled these individual components to assess the relative efficacy of each technique independently. The approaches that have been most extensively studied can be generally grouped into four main categories based on the therapeutic components given the most emphasis, or the specific way in which these components were packaged, although there is overlap between these groups:

- **Exposure-based therapies** (ET) emphasize in-vivo, imaginal, and narrative (oral and/or written) exposure, but also generally include elements of cognitive restructuring (e.g. evaluating the accuracy of beliefs about danger) as well as relaxation techniques and self-monitoring of anxiety. Examples of therapies that include a focus on exposure include Prolonged Exposure Therapy, Brief Eclectic Psychotherapy, Narrative Therapy, written exposure therapies, and many of the cognitive therapy packages that also incorporate in-vivo and imaginal/narrative exposure.
- **Cognitive-based therapies** (CT) emphasize cognitive restructuring (challenging automatic or acquired beliefs connected to the traumatic event, such as beliefs about safety or trust) but also include relaxation techniques and discussion/narration of the traumatic event either orally and/or through writing. Examples include Cognitive Processing Therapy and various cognitive therapy packages tested in RCTs
- **Stress Inoculation Training** (SIT) (the specific anxiety management package most extensively studied in the PTSD literature), places more emphasis on breathing retraining and muscle relaxation, but also includes cognitive elements (self-dialogue, thought stopping, role playing) and, often, exposure techniques (in-vivo exposure, narration of traumatic event).
- **Eye Movement Desensitization and Reprocessing** (EMDR) (extensively studied in a large number of RCTs) closely resembles other CBT modalities in that there is an exposure component (e.g. talking about the traumatic event and/or holding distressing traumatic memories in mind without verbalizing them) combined with a cognitive component (e.g., identifying a negative cognition, an alternative positive cognition, and assessing the validity of the cognition), and relaxation/self-monitoring techniques (e.g., breathing, “body scan”). Alternating eye-movements are part of the classic EMDR technique (and the name of this type of treatment); however, comparable effect sizes have been achieved with or without eye movements or other forms of distraction or kinesthetic stimulation. Although the mechanisms of effectiveness in EMDR have yet to be determined, it is likely that they are similar to other trauma-focused exposure and cognitive-based therapies.

### Treatment Options:

1. Strongly recommend that patients who are diagnosed with PTSD should be offered one of the evidence-based trauma-focused psychotherapeutic interventions that include components of exposure and/or cognitive restructuring; or stress inoculation training. [A]

The choice of a specific approach should be based on the severity of the symptoms, clinician expertise in one or more of these treatment methods and patient preference, and may include an exposure-based therapy (e.g., Prolonged Exposure), a cognitive-based therapy (e.g., Cognitive Processing Therapy), stress management therapy (e.g., Stress Inoculation Therapy), or Eye Movement Desensitization and Reprocessing Therapy (EMDR).

2. Relaxation techniques should be considered as a component of treatment approaches for ASD or PTSD in alleviating symptoms associated with physiological hyper-reactivity. [C]
3. Imagery Rehearsal Therapy [IRT] can be considered for treatment of nightmares and sleep disruption. [C]
4. Brief Psychodynamic Therapy can be considered for patients with PTSD. [C]
5. Hypnotic Techniques can be considered, especially for symptoms associated with PTSD, such as pain, anxiety, dissociation, and nightmares, for which hypnosis has been successfully used. [C]
6. There is insufficient evidence to recommend for or against Dialectical Behavioral Therapy (DBT) as first-line treatment for PTSD [I];
  - Dialectical Behavioral Therapy can be considered for patients with a borderline personality disorder typified by parasuicidal behaviors. [B]
7. There is insufficient evidence to recommend for or against Family or Couples Therapy as first-line treatment for PTSD. Family or Couples Therapy may be considered in managing PTSD-related family disruption or conflict, increasing support, or improving communication. [I]
8. Group Therapy may be considered for treatment of PTSD. [C]
  - There is insufficient evidence to favor any particular type of group therapy over other types.
  - Patients being considered for group therapy should exhibit acceptance for the rationale for trauma work and willingness to self-disclose in a group.
9. Consider augmenting with other effective evidence-based interventions for patients who do not respond to a single approach.
10. Supportive psychotherapy is not considered to be effective for the treatment of PTSD. However, multiple studies have shown that supportive interventions are significantly more helpful than no treatment, and they may be helpful in preventing relapse in patients who have reasonable control over their symptoms and are not in severe and acute distress.

**Note:**

Approaches may also be beneficial as parts of an effectively integrated approach. Most experienced therapists integrate diverse therapies, which are not mutually exclusive, in a fashion that is designed to be especially beneficial to a given patient.

**Delivery of care:**

1. Telemedicine interventions that involve person-to-person individual treatment sessions appear to have similar efficacy and satisfaction clinically as a direct face-to-face interaction, though data are much more limited than for face-to-face encounters. [C]
  - a. Telemedicine interventions are recommended when face-to-face interventions are not feasible due to geographic distance between patient and provider or other barriers to patient access (e.g., agoraphobia, physical disability); when the patient would benefit from more frequent contact than is feasible with face-to-face sessions; or when the patient declines more traditional mental health interventions.
  - b. Providers using telemedicine interventions should endeavor to maintain and strengthen the therapeutic relationship, build patient rapport, stress practice and assignment completion, and ensure adequacy of safety protocols using similar techniques as they do in a face-to-face session.
  - c. Providers using technology-assisted interventions should take steps to ensure that their work complies with the regulations and procedures of the organization in which they are employed, legal standards, and the ethical standards of their professions. Patient confidentiality and safety should be monitored closely.

2. There is insufficient evidence to recommend for or against web-based interventions as a stand-alone intervention or as an alternative to standard mental health treatment for PTSD. [I]

If web-based interventions are used:

- a. Clinicians should carefully review the content of any web-based materials to ensure their accuracy and ethical application before recommending use to patients.
- b. A web-based approach may be used where face-to-face interventions are not feasible (e.g., geography limits access to other forms of treatment) or when patients decline more traditional mental health interventions. It has also been suggested that web-based interventions may provide more confidentiality than more traditional approaches.
- c. Providers should regularly encourage patients to complete the intervention and endeavor to maintain and strengthen the therapeutic relationship, build patient rapport, stress practice and assignment completion, and ensure adequacy of safety protocols. Availability of telephone contacts for initial assessment or other reasons (e.g. emergencies, suicidality/homicidality, or follow-up of specific problems) should be considered.
- d. Providers using technology-assisted interventions should take steps to ensure that their work complies with the regulations and procedures of the organization in which they are employed, legal standards, and the ethical standards of their professions. Patient confidentiality and safety should be monitored closely.

### *Annotation C. Pharmacotherapy for PTSD*

#### **C-1 General Recommendations:**

1. Risks and benefits of long-term pharmacotherapy should be discussed prior to starting medication and should be a continued discussion item during treatment.
2. Monotherapy therapeutic trial should be optimized before proceeding to subsequent strategies by monitoring outcomes, maximizing dosage (medication or psychotherapy), and allowing sufficient response time (for at least 8 weeks). [C]
3. If there is some response and patient is tolerating the drug, continue for at least another 4 weeks.
4. If the drug is not tolerated, discontinue the current agent and switch to another effective medication.
5. If no improvement is observed at 8 weeks consider:
  - a. Increasing the dose of the initial drug to maximum tolerated
  - b. Discontinuing the current agent and switching to another effective medication
6. Recommend assessment of adherence to medication at each visit.
7. Recommend assessment of side effects and management to minimize or alleviate adverse effects.
8. Assess for treatment burden (e.g., medication adverse effects, attending appointments) after initiating or changing treatment when the patient is non-adherent to treatment or when the patient is not responding to treatment.
9. Since PTSD is a chronic disorder, responders to pharmacotherapy may need to continue medication indefinitely; however, it is recommended that maintenance treatment should be periodically reassessed.
10. Providers should give simple educational messages regarding antidepressant use (e.g., take daily, understand gradual nature of benefits, continue even when feeling better, medication may cause some transient side effects, along with specific instructions on how to address issues or concerns, and when to contact the provider) in order to increase adherence to treatment in the acute phase. [B]

**Table I–2.2 Pharmacotherapy Interventions for Treatment of PTSD**

Effect = Balance of Benefit and Harm				
SR	Significant Benefit	Some Benefit	Unknown Benefit	No Benefit
A	<ul style="list-style-type: none"> <li>• SSRIs</li> <li>• SNRIs</li> </ul>	--	--	--
B	--	<ul style="list-style-type: none"> <li>• Mirtazapine</li> <li>• Prazosin (for sleep/nightmares)</li> <li>• TCAs</li> <li>• Nefazodone [Caution*]</li> <li>• MAOIs (phenelzine) [Caution*]</li> </ul>	--	--
C	--	--	<ul style="list-style-type: none"> <li>• Prazosin (for global PTSD)</li> </ul>	--
D	--	--	--	<ul style="list-style-type: none"> <li>• Benzodiazepines [HARM]</li> <li>• Tiagabine</li> <li>• Guanfacine</li> <li>• Valproate</li> <li>• Topiramate</li> <li>• Risperidone</li> </ul>
I	--	--	<ul style="list-style-type: none"> <li>• Atypical antipsychotics (monotherapy)</li> <li>• Atypical antipsychotics (as adjunct)</li> <li>• Conventional antipsychotics</li> <li>• Buspirone</li> <li>• Non-benzodiazepine hypnotics</li> <li>• Bupropion</li> <li>• Trazodone (adjunctive)</li> <li>• Gabapentin</li> <li>• Lamotrigine</li> <li>• Propranolol</li> <li>• Clonidine</li> </ul>	--

SR = Strength of recommendation (see Introduction);

\* Attention to drug to-drug and dietary interactions

**C-2 Monotherapy:**

11. Strongly recommend that patients diagnosed with PTSD should be offered selective serotonin reuptake inhibitors (SSRIs), for which fluoxetine, paroxetine, or sertraline have the strongest support, or serotonin norepinephrine reuptake inhibitors (SNRIs), for which venlafaxine has the strongest support, for the treatment of PTSD. [A]
12. Recommend mirtazapine, nefazodone, tricyclic antidepressants (amitriptyline and imipramine), or monoamine oxidase inhibitors (phenelzine) for the treatment of PTSD. [B]
13. Recommend against the use of guanfacine, anticonvulsants (tiagabine, topiramate, or valproate) as monotherapy in the management of PTSD. [D]

14. The existing evidence does not support the use of bupropion, buspirone, trazodone, anticonvulsants (lamotrigine or gabapentin), or atypical antipsychotics as monotherapy in the management of PTSD. [I]
15. There is evidence against the use of benzodiazepines in the management of PTSD. [D]
16. There is insufficient evidence to support the use of prazosin as monotherapy in the management of PTSD. [I]

### **C-3 Augmented Therapy for PTSD:**

17. Recommend against the use of risperidone as adjunctive therapy [D]. There is insufficient evidence to recommend for or against the use of any other atypical antipsychotic as an adjunctive therapy for the treatment of PTSD. [I]
18. Recommend adjunctive treatment with prazosin for sleep/nightmares. [B]
19. There is insufficient evidence to recommend a sympatholytic or an anticonvulsant as an adjunctive therapy for the treatment of PTSD. [I]

## *Annotation D. Adjunctive Services*

### **D-1 Psychosocial Rehabilitation:**

1. Consider psychosocial rehabilitation techniques once the client and clinician identify the following kinds of problems associated with the diagnosis of PTSD: persistent high-risk behaviors, lack of self-care/independent living skills, homelessness, interactions with a family that does not understand PTSD, socially inactive, unemployed, and encounters with barriers to various forms of treatment/rehabilitation services.
2. Patient and clinician should determine whether such problems are associated with core symptoms of PTSD and, if so, ensure that rehabilitation techniques are used as a contextual vehicle for alleviating PTSD symptoms.
3. Psychosocial rehabilitation should occur concurrently or shortly after a course of treatment for PTSD, since psychosocial rehabilitation is not trauma-focused.

Models of Psychosocial Rehabilitation Services include:

- Patient education services
- Self-care and independent living skills techniques
- Supported housing
- Marital/family skills training
- Social skills training
- Vocational rehabilitation
- Case management
- Physical health and well-being and computer-assisted self-management.

### **D-2 Spiritual Support:**

1. Ensure patient access to spiritual care when sought.
2. Assess for spiritual needs.
3. Provide opportunities for grieving for losses (providing space and opportunities for prayers, mantras, rites, rituals, and end-of-life care, as determined important by the patient).

**Table I-2.3 Adjunctive Problem-Focused Methods/Services for PTSD**

If the Client and Clinician Together Conclude That the Patient with PTSD:		Service/Training
1	Is not fully informed about aspects of health needs and does not avoid high-risk behaviors (e.g., PTSD, substance use)	Provide patient education
2	Does not have sufficient self-care and independent living skills	Refer to self-care/independent living skills training services
3	Does not have safe, decent, affordable, stable housing that is consistent with treatment goals	Use and/or refer to supported housing services
4	Does not have a family that is actively supportive and/or knowledgeable about treatment for PTSD	Implement family skills training
5	Is not socially active	Implement social skills training
6	Does not have a job that provides adequate income and/or fully uses his or her training and skills	Implement vocational rehabilitation training
7	Is unable to locate and coordinate access to services such as those listed above	Use case management services
8	Does request spiritual support	Provide access to religious/spiritual advisors and/or other resources
<b>Other Conditions</b>		
9	Does have a borderline personality disorder typified by parasuicidal behaviors	Consider Dialectical Behavioral Therapy
10	Does have concurrent substance abuse problem	Integrated PTSD substance abuse treatment (e.g., Seeking Safety)

*Annotation E. Somatic Treatments*

**E-1 Biomedical Somatic Therapies:**

1. There is insufficient evidence to recommend the use of any of the Biomedical Somatic Therapies for first-line treatment of PTSD. [D]
2. ECT and rTMS may be considered as an alternative in chronic, severe, medication-resistant, and psychotherapy-resistant PTSD. [B]

**E-2 Acupuncture:**

1. Acupuncture may be considered as treatment for patients with PTSD. [B]



### *Annotation F. Complementary and Alternative Medicine (CAM)*

1. There is insufficient evidence to recommend CAM approaches as first line treatments for PTSD. [I]
2. CAM approaches that facilitate a relaxation response (e.g. mindfulness, yoga, acupuncture, massage, and others) may be considered for adjunctive treatment of hyperarousal symptoms, although there is no evidence that these are more effective than standard stress inoculation techniques. [I]
3. CAM approaches may be considered as adjunctive approaches to address some co-morbid conditions (e.g. acupuncture for pain). [C]
4. CAM may facilitate engagement in medical care and may be considered in some patients who refuse evidence-based treatments. However, providers should discuss the evidence for effectiveness and risk-benefits of different options, and ensure that the patient is appropriately informed.



### 3. SYMPTOM-SPECIFIC MANAGEMENT

*(Recommendations based on consensus of THE WORKING GROUP clinical experts)*

This Module includes treatment recommendations for a selected list of physical symptoms that are common in patients presenting with posttraumatic stress symptoms.

Survivors of trauma may not complain directly of PTSD symptoms such as re-experiencing or avoidance. Instead, they may complain of sleeping problems. It is therefore vital that all opportunities for identifying PTSD should be taken. Questioning the individuals as well as family members, co-workers or buddies will also improve the recognition of PTSD. When seeking to identify PTSD, the primary care team should consider asking specific questions about sleep problems, (including flashbacks and nightmares) or hyperarousal (including an exaggerated startle response or sleep disturbance). Providers should actively seek out signs of suicidal ideation and increased anxiety and agitation.

Patients with chronic pain, particularly headache disorders and fibromyalgia (FM), associated with psychological traumas need a special management strategy. Diagnosis of headache disorders and FM in traumatized patients and obtaining the clinical history of a traumatic event or diagnosing PTSD in chronic pain patients is of great importance.

#### *Annotation A. Sleep Disturbances*

##### **A-1 Sleep Disturbance:**

1. Encourage patients to practice good sleep hygiene, including:
  - Restricting the night-time sleep period to about eight hours
  - Waking at a regular time
  - Arising from bed at a regular time
  - Avoiding going to bed too early
  - Avoiding alcohol
  - Avoiding stimulants, caffeinated beverages, power/energy drinks, nicotine and over-the-counter medications
  - Avoiding stimulating activities, light, noise and temperature extremes before bedtime (e.g., exercise, video games, T.V.) or in the sleeping area
  - Reducing (to less than 30 minutes) or abolishing daytime naps
  - Practicing relaxation techniques
  - Engaging in moderate exercise, but not immediately before bedtime.
2. Offer Cognitive Behavioral Therapy for insomnia, which may include:
  - Educating about proper sleep habits and sleep needs
  - Correcting false and unrealistic beliefs/concerns about sleep
  - Identifying and addressing anxious, automatic thoughts which disrupt sleep.
3. Consider adjunctive therapy for nightmares using prazosin. [B]
4. Any significant change in sleep patterns should trigger clinical reassessment in order to rule out worsening or new onset of co-morbid conditions.

## A-2 Insomnia:

1. Monitor symptoms to assess improvement or deterioration and reassess accordingly.
2. Explore cause(s) for insomnia, including co-morbid conditions.
3. Begin treatment for insomnia with non-pharmacologic treatments including sleep hygiene and cognitive behavioral treatment (See recommendation for Sleep Disturbances).
4. The selection of sleep agents for the treatment of insomnia in PTSD patients may be impacted by other treatment decisions (e.g., medications already prescribed for the treatment of PTSD, depression, TBI, pain, or concurrent substance abuse/withdrawal) and social/environmental/logistical concerns associated with deployment.
  - a. **Trazodone** may be helpful in management of insomnia and may also supplement the action of other antidepressants.
  - b. **Hypnotics** are a second line approach to the management of insomnia and should only be used for short periods of time. Should hypnotic therapy be indicated, the newer generation of non-benzodiazepines (e.g. zolpidem, eszopiclone, ramelteon) may have a safety advantage by virtue of their shorter half-life and lower risk of dependency. Patients should be warned of and monitored for the possibility of acute confusional states/bizarre sleep behaviors associated with hypnotic use. Benzodiazepines can be effective in chronic insomnia but may have significant adverse effects (confusion, sedation, intoxication) and significant risk of dependency.
  - c. **Atypical antipsychotics** should be avoided due to potential adverse effects but may be of value when agitation or other symptoms are severe.
  - d. If nightmares remain severe, consider adjunctive treatment with **prazosin**. [B]
  - e. If symptoms persist or worsen – refer for evaluation and treatment of insomnia.

Additional information of management of insomnia can be found in VHA Pharmacy Benefit Management (PBM) guideline for Insomnia: <http://www.pbm.va.gov/ClinicalRecommendations.aspx>

### *Annotation B. Pain*

1. Recommend pain assessment using a '0 to 10' scale.
2. Obtain a thorough biopsychosocial history and assess for other medical and psychiatric problems, including risk assessment for suicidal and homicidal ideation and misuse of substances, such as drugs, alcohol, over-the-counter and prescription drugs, or narcotics.
3. Assessment should include questions about the nature of the pain and likely etiology (i.e., musculoskeletal and neuropathic), locations, quality, quantity, triggers, intensity, and duration of the pain, as well as aggravating and relieving factors.
4. Assessment should include evaluation of the impact of pain on function and activities, pain-related disability, or interference with daily activities.
5. Assessment should include the identification of avoidance behaviors that contribute to emotional distress and/or impaired functioning.
6. Management of pain should be multidisciplinary, addressing the physical, social, psychological, and spiritual components of pain in an individualized treatment plan that is tailored to the type of pain. [C]
7. Selection of treatment options should balance the benefits of pain control with possible adverse effects (especially sedating medications) on the individual's ability to participate in, and benefit from, PTSD treatment. [I]

8. Musculoskeletal pain syndromes can respond to correcting the underlying condition and treatment with non-steroidal anti-inflammatory drugs (NSAIDs).
9. When appropriate, recommend use of non-pharmacological modalities for pain control, such as biofeedback, massage, imaging therapy, physical therapy, and complementary alternative modalities (yoga, meditation, acupuncture). [C]
10. Centrally acting medications should be used in caution in patients with PTSD, as they may cause confusion and deterioration of cognitive performance and interfere with the recovery process.
  - a. If required, lower doses of opioid therapy or other centrally acting analgesics should be used for short duration with transition to the use of NSAIDs. [C]
11. Consider offering Cognitive Behavioral Therapy, which may include:
  - a. Encouraging increasing activity by setting goals
  - b. Correcting false and unrealistic beliefs/concerns about pain
  - c. Teaching cognitive and behavioral coping skills (e.g., activity pacing)
  - d. Practicing and consolidation of coping skills and reinforcement of use.

### *Annotation C. Irritability, Severe Agitation, or Anger*

1. Assess the nature of symptoms, severity, and dangerousness. Consider using standardized Anger Scales, such as Spielberger's State-Trait Anger Expression Inventory, to quantify.
2. Explore for cause of symptoms and follow-up to monitor change.
3. Consider referral to specialty care for counseling or for marital or family counseling as indicated. Offer referral for:
  - a. Anger Management therapy
  - b. Training in exercise and relaxation techniques.
4. Promote participation in enjoyable activities - especially with family/ loved ones.
5. Promote sleep and relaxation.
6. Avoid stimulants and other substances (caffeine, alcohol).
7. Address pain (see pain management).
8. Avoid benzodiazepines.
9. Consider SSRIs/SNRIs
  - a. If not responding to SSRIs/SNRIs and other non-pharmacological interventions, consider low-dose anti-adrenergics or low-dose atypical antipsychotics (risperidone, quetiapine).
  - b. If not responding or worsening, refer to specialty care.

## ACRONYM LIST

AAP	Atypical Anti-psychotics	MIRT	Mirtazapine
APA	American Psychiatric Association	MMSE	Mini-Mental State Examination
ASD	Acute Stress Disorder	MS	Musculoskeletal
ASR	Acute Stress Reaction	MSE	Mental Status Examination
CAM	Complimentary and Alternative Medicine	mTBI	Mild Traumatic Brain Injury
CAPS	Clinician-Administered PTSD Scale	MVA	Motor vehicle accident
CBC	Complete blood count	NFZ	Nefazodone
CBT	Cognitive Behavioral Therapy	NS	Nervous system
CPG	Clinical practice guideline	NSAID	Non-steroidal anti-inflammatory drug
COSR	Combat and operational stress reactions	OEF/OIF/ OND	Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn
CT	Cognitive-based Therapy	OTC	Over-the-counter
CV	Cardiovascular	PCL	Post-traumatic Stress Disorder Checklist
DBT	Dialectical Behavioral Therapy	PC-PTSD	Primary Care-PTSD Screen
DoD	Department of Defense	PFA	Psychological first aid
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders (4th edition)	PHQ-9	Patient Health Questionnaire 9
ECT	Electroconvulsive Therapy	PTSD	Post-traumatic Stress Disorder
EEG	Electroencephalography	RCT	Randomized Controlled Trial
EKG	Electrocardiogram	rTMS	Repetitive transcranial magnetic stimulation
EMDR	Eye Movement Desensitization and Reprocessing	SIT	Stress Inoculation Therapy
ET	Exposure-based Therapy	SR	Strength of Recommendation
ETOH	Ethanol	SNRIs	Serotonin Norepinephrine Reuptake Inhibitors
FM	Fibromyalgia	SSRIs	Selective Serotonin Reuptake Inhibitors
GU	Genitourinary	SUD	Substance Use Disorder
HCG	Human chorionic gonadotropin	TBI	Traumatic Brain Injury
HIV	Human immunodeficiency virus	TCAs	Tricyclic Antidepressants
IRT	Imagery Rehearsal Therapy	Tox	Toxicology
LOC	Level of consciousness	TSH	Thyroid Stimulating Hormone
LOF	Level of function	USPSTF	U.S. Preventive Service Task Force
MAOI	Monoamine oxidase inhibitor	VA	Veterans Affairs
MDD	Major Depressive Disorder	VHA	Veterans Health Administration
		WG	Working Group









<http://www.healthquality.va.gov>  
<https://www.qmo.amedd.army.mil>